Title: Making Sense of Cranial Osteopathy: An Interpretative Phenomenological Analysis

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Making Sense of Cranial Osteopathy:

An Interpretative Phenomenological Analysis

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I, Amanda Banton, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

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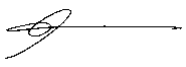
Signed: 

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ABSTRACT

Title: Making Sense of Cranial Osteopathy: an Interpretative Phenomenological Analysis

Purpose: This study arose from a praxial problem: how best to communicate with patients about the mechanism of cranial osteopathy. The problem was explored in a way that presented cranial osteopathy as a complex, multi-faceted phenomenon in the domain of healthcare practice. The resulting research question was phenomenologically inflected and was articulated as 'What sense do osteopaths and their patients make of the phenomenon of cranial osteopathy?' The concept of 'sense-making' was applied to both the *manner* in which osteopaths and their patients experience and understand cranial osteopathy and also the *meaning* that emerges in the course of giving or receiving cranial osteopathic treatment.

Method: Interpretative Phenomenological Analysis (IPA) was used to explore cranial osteopaths' understanding and lived experience of their practice and to simultaneously explore patients' understanding and lived experience of cranial osteopathy. Four cranial osteopaths who were Fellows of the Sutherland Cranial College of Osteopathy participated, as did a patient each of theirs. The cranial osteopath participants were experienced practitioners and the patient participants were people who had had positive experiences of cranial osteopathy. The participants were interviewed about their lived experience and understanding of the phenomenon of cranial osteopathy. The semi-structured interviews were audio-recorded, transcribed and analysed by the researcher. The researcher kept a reflexive diary and an account of her theoretical fore-structure, in order to understand and audit the influences on her hermeneutic analysis of the data. From the data analysis,

ongoing reflexion on praxis and a reading of the theoretical literature emerged three Super-Ordinate Themes and a hermeneutic model of cranial osteopathy.

Findings: The IPA revealed that both patients and practitioners establish epistemological grounds for their sense-making about their embodied experience of cranial osteopathy (Super-Ordinate Theme 1: Making sense of sense-making), that they use embodied metaphor and linguistic meta-metaphor to understand their lived experience of cranial osteopathy (Super-Ordinate Theme 2: Metaphors for mechanisms), and that the mechanism of cranial osteopathy is considered by both patients and practitioners to arise from the therapeutic relationship (Super-Ordinate Theme 3: The meaningful osteopathic relationship).

Conclusions: The main outcome of the study is a hermeneutic model of cranial osteopathy, which posits that the shared, embodied therapeutic relationship facilitates a collaborative rapport which enables the osteopath and the patient to come to an understanding of the source of the patient's malady, and that furthermore this understanding supports the mobilisation of the physiological mechanisms of healing to 'unconceal' health.

Keywords: Cranial osteopathy, phenomenology, enactive sense-making, embodied cognition and metaphor.

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LIST OF ACRONYMS AND ABBREVIATIONS

AT	Alexander Technique
CAM(s)	Complementary and/or Alternative Medicine(s)
CSF	Cerebro-spinal fluid
CST	Cranio-sacral therapy
CT	C-Tactile (fibres)
EBM	Evidence-based medicine
EBP	Evidence-based practice
FSCCO	Fellow of the Sutherland Cranial College of Osteopathy
GOsC	General Osteopathic Council
IO	Institute of Osteopathy
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
OIA	Osteopathic International Alliance
PRM	Primary Respiratory Mechanism
SCCO	Sutherland Cranial College of Osteopathy
UCO	University College of Osteopathy

A note on pronouns: I have used gendered third-person pronouns where relevant and have adopted the neutral third-person plural form in favour of the less fluent s/he; his-him/hers-her constructions.

Word count: 76,098.

CHAPTER 1: INTRODUCTION

1.1. Introduction to the Study

This study is an interpretative phenomenological analysis (IPA) of the accounts of osteopaths and patients who practice and receive cranial osteopathy. Cranial osteopathy is a form of osteopathy that emerged from the research and teaching of W.G. Sutherland (1873-1954), an American osteopath. It has become popular around the world in places where osteopathy or osteopathic medicine are practised (OIA, 2013). In the UK, osteopathy has been a regulated profession following the passage of *The Osteopaths Act* in 1993 and its enactment in 2000. Its practitioners mostly operate in the sphere of private health care. Osteopathy is considered, in the UK, to be a form of complementary medicine (NHS, 2016) that has recently been approved by the NHS as an allied health profession (NHS, 2017). This status can be considered to contribute to the legitimacy of osteopathy as an independent system of musculoskeletal healthcare that can complement the provision of musculoskeletal health care through the NHS.

In order to accord with expectations that regulated health professionals should deliver healthcare that can be demonstrated to be safe and effective, osteopaths are encouraged to work in ways that pay heed to the principles of Evidence-Based Medicine (EBM) (Sackett *et al.*, 1996) – or the form that applies to healthcare practices, Evidence-Based Practice (EBP) (Lucas and Moran, 2008 and 2011; Vogel, 2015). There are signs that UK osteopaths are becoming more open to working with an evidence-informed approach (Humpage, 2011; Weber and Rajendran, 2018), for example by taking into account clinical practice guidelines developed by the National Institute for Health and Care Excellence (NICE) into the

management and treatment of patients with non-specific low back pain (Inman and Thomson, 2019).

In a recent systematic review, cranial osteopathy has been described as a specialised form of osteopathy that is "primarily concerned with the study of the anatomic and physiologic mechanisms in the cranium and their interrelationship with the body as a whole, including a system of diagnostic and therapeutic modalities with application to prevent and treat disease" (Jäkel and von Hauenschild, 2012, p. 685). The systematic review considered the eligibility of 159 studies for inclusion, but, after assessment, was only able to include eight of them. Seven of these studies were randomised controlled trials with moderate methodological quality and a level of heterogeneity that meant it was not possible for the authors to draw definitive conclusions about the safety and efficacy of cranial osteopathy (*ibid.*). A further systematic review by Guillaud *et al.* (2016, p. 2) concluded, similarly, that "methodologically strong evidence on the reliability of diagnostic procedures and the efficacy of techniques and therapeutic strategies in cranial osteopathy is almost non-existent." Critics of cranial osteopathy suggest that until evidence of its safety and efficacy can be demonstrated, and until its mechanism of therapeutic effect can be isolated and explained, it should not be taught in osteopathic curricula or promoted as a branch of mainstream osteopathy (Hartman, 2006a; McGrath, 2015).

This study does *not* aim to supply evidence to supplement the deficiency in evidence identified by Jäkel and von Hauenschild (2012) or respond to the criticisms of Hartman (2006a) and McGrath (2015). Instead, it is an exploration of cranial osteopathy as a multi-

faceted phenomenon – an attempt to interrogate not only the therapeutic practice of cranial osteopathy, but also to consider its relationship with the domain of EBP. The study explores cranial osteopathy not so much as a branch of osteopathy or osteopathic medicine but as a cultural healthcare practice with embodiment at its heart. Its focus is on cranial osteopathy as it is experienced and delivered by its patients and practitioners. Its aim is to understand how osteopaths and their patients understand its mechanism – i.e. how it can be considered to 'work' – and to contribute to an understanding of its relevance and popularity in the UK in the early twenty-first century (Fawkes *et al.*, 2014). With a focus on what cranial osteopathy *means* to its patients and practitioners, this study contributes not only to an understanding of this under-researched practice but also to the evolution of an EBM that foregrounds the concerns, values, experience and agency of patients (Greenhalgh *et al.*, 2015; Kelly *et al.* 2015; Weaver, 2015).

1.2. Introduction to the Research Problem

The concept of the project had its origins in the researcher's first steps to becoming an osteopath in 2002. Prior to beginning my osteopathic training at the London School of Osteopathy, I read a book that made an impression on me: *Osteopathic Medicine*, by Walter McKone (2001). It is a book that proposes a Goethean[1] reading of the osteopathic canon,

[1] McKone (2001) explores the scientific method of the author and philosopher, J.W. von Goethe (1749-1832), and summarises the Goethean scientific paradigm as organocentric and holistic, with an epistemology that is "holographic-organic" (*ibid*., p. 39). According to McKone, the Goethean scientist utilises a non-verbal mode of consciousness to "become part of the experience witnessed" (*ibid*., p. 36), departing from the dominant post-Enlightenment western scientific paradigm which requires an analytical, rather than intuitive, understanding of the objectivist external world. McKone speculates that Goethe's influence might have reached the founder of osteopathy, A.T. Still (1828-1917), via the settlement across the USA of German intellectuals following the revolutions of 1848-1849.

and, as such, makes a stand for the profession of osteopathy to retain its independence from the orthodoxy of western medicine. After reading *Osteopathic Medicine*, I recorded my impressions of McKone's arguments on the final page of my own copy of the book:

> "The philosophy of osteopathy, derived from Still's non-dualistic approach to understanding the unity of the mind and the body, may be described as organic, ecological and holistic. Still recognized that the osteopath participates in the healing of a patient, by attuning to the internally self-organizing system of the mind-body, and not by directing it. The philosophy of osteopathy is not unique to it: there are other healing sciences with the field of 'somatics' that exemplify the paradigm that it is the dynamic relationship between the practitioner and the patient which effects healing by stimulating the patient's own systems of self-care. The philosophy is not familiar to allopathic medicine, which is concerned with pathology, analysis, aetiology and the separation between physician and patient. These alternative philosophies have been given metaphorical form by comparing them to Hygeia and Panakea (participation vs intervention; organic vs analytical)"
>
> Banton (2002); see Appendix 1.

McKone's account of osteopathic medicine proposes that it was, at the turn of the twenty-first century, as it had always been since its foundation at the turn of the twentieth, an alternative system of healthcare science, defined in contradistinction to orthodox, western

biomedicine. Influenced by McKone (2001), I undertook my osteopathic training with the predisposition to enter an 'alternative' – rather than 'complementary' – healthcare profession (Ning, 2012), with the expectation that I would be entering a profession with its roots in a non-orthodox philosophical paradigm. Additionally, on account of my own personal experience as an osteopathic patient, I had become interested in the special relationship between osteopathic practitioners and patients. I read and re-read one particular passage in McKone (2001):

> "Osteopathic medicine is a continual coming into knowing that does not resolve itself in either knowing or holding onto certainty as a consciousness. At its purest form, osteopathy only exists whilst it is being performed, as it demands the mechanism of the patient's body and the osteopath at the same time"
>
> McKone (2001), p. vii.

My margin-note, written in 2002, was this: "Osteopathy not a discipline so much as a dynamic", indicating that I was intrigued by what I perceived as the quasi-sacramental operation of the osteopathic mechanism of effect, which was said to involve the contemporaneous commingling of the 'mechanism of the patient's body' with some action or intention of the osteopath.

During my osteopathic training, I was unable to find a source for this concept until, following the completion of my undergraduate osteopathic studies, I began my post-graduate training

as a cranial osteopath, with the Sutherland Cranial College (as it was then known) in 2008. I had been familiar with cranial osteopathy as a patient before beginning my osteopathic training, and had found it a helpful approach for dealing with headaches; but my experience as a patient had given me no insight into the theory behind the practice. During my training with the Sutherland Cranial College of Osteopathy (SCCO, as it began to be known in 2013), I began to have some experiential inklings about the interpersonal and aesthetic osteopath-patient therapeutic relationship. I became a Fellow of the SCCO (FSCCO) in 2014 and found myself drawn into conversations with my patients about the mechanism of cranial osteopathy. Finding it professionally and personally challenging to be able to communicate with my patients about the theoretical and subtle experiential aspects of cranial osteopathy, I was motivated to undertake a research project that would equip me to explore – and hopefully go on to explain – how I had come to further understand my initial insight that: "the osteopath participates in the healing of a patient, by attuning to the internally self-organizing system of the mind-body, and not by directing it" (Banton, 2002; see Appendix 1). The research problem thus began to take shape, as I cogitated upon this enigmatic purported mechanism of osteopathy that seemed to require a specific shared investment of both osteopath and patient – an investment not adequately described in accounts of patient-practitioner relationships commonly described in western medical literature.

1.3. Originality and Clinical Relevance of the Study

The present study is the first to explore the lived experience of patients and practitioners of cranial osteopathy in such a way as to investigate their sense-making of its therapeutic mechanism. It has utilised interpretative phenomenological analysis in a novel way to

examine embodied sense-making and meaning-disclosure that occurs at prenoetic and pre-reflective levels.[2] The main outcome of the study is a hermeneutic model of cranial osteopathy that has relevance to the wider profession of osteopathy as it continues to grapple with its identity and relationship with EBM. It also has relevance to other mainstream, complementary and alternative therapeutic practices that utilise touch and bodywork, such as physiotherapy, chiropractic, massage, Alexander Technique, Shiatsu and Reiki.

1.4. Professional and Personal Stance of the Researcher

I am a UK-trained and registered osteopath, working in private practice in the UK and lecturing on Level 7 (i.e. Master's) Osteopathy programmes during the conduct of the study. I studied cranial osteopathy with the UK-based Sutherland Cranial College of Osteopathy (SCCO) and completed the college's post-graduate pathway, becoming a Fellow in 2014. I used to be a member of the SCCO Research Sub-Committee, but stood down in order to avoid possible conflicts of interest during the conduct of the study. I regularly engage in conversations with patients about the phenomenon of cranial osteopathy and have a personal interest in exploring the lived experience[3] of cranial osteopathy, in order to inform

[2] i.e. within the domain of embodied cognition where concepts are understood that are incapable of being expressed in words – i.e. are ineffable (prenoetic); or where they are understood prior to emergence to reflective thought (pre-reflective).

[3] In the phenomenological sense, 'lived experience' means "situated, immediate activities and encounters in everyday experience, pre-reflexively taken for granted as reality rather than as something perceived or represented", Oxford Dictionary of Media and Communication (2016), 2nd edn.

my communication and shared decision-making with my patients. My academic interests, prior to training as an osteopath, were – and remain – in the arts and humanities.

I state explicitly that the study has evolved from personal praxial reflection. The research question, study population, interview schedule and data analysis were, in the planning, and have been, in the execution, all examined in relation to my own experience and perspective as a cranial osteopath and a Fellow of the SCCO.

1.5. Thesis Structure

Chapter 2 is an evaluative literature review that introduces the profession of osteopathy and the practice of cranial osteopathy in a way that sheds a historicist and critical light on osteopathy's professionalisation, therapeutic claims, relationship with the principles of EBM, and its popularity within western culture alongside other complementary and alternative therapies. It also explores phenomenological and enactivist models of embodied cognition and a hermeneutic model of medicine proposed by Svenaeus (2000a, 2000b, 2003). It concludes with an exploration of the therapeutic use of touch and a summary of recent cross-disciplinary research into affective touch.

Chapter 3 is an in-depth account of the methodological challenges and decisions taken in order to situate the lived experience and practice of cranial osteopathy within a plural, hermeneutic realist field of enquiry. The chapter begins with a survey of the philosophical and praxial context of the research problem, analysing the tensions between the meaningful practice of cranial osteopathy and the principles of EBM. It moves on to introducing an approach to phenomenological research influenced by the readings of Heidegger presented

by Dreyfus (1980, 1991) and Sheehan (2014, 2015). It concludes with the justification for choosing IPA as a suitable research method with which to explore the research problem.

Chapter 4 describes, in detail, the study design and research methods utilised in the conduct of the study. It explains the ethical considerations that arose in the planning and the conduct of the study. It sets out and justifies the minor modifications that were made to the study design.

Chapter 5 presents the findings of the study. Idiographic introductions are made to the four patient and four osteopath participants. The Super-Ordinate Themes, Patient Themes and Osteopath Themes are set out in descriptive text as well as tables. They are then presented with evidence in the form of quotations from each of the participants, embedded within a hermeneutic analysis that presents a sense of the lived experience of each of the participants individually and a *Gestalt* interpretation of the data as a whole.

Chapter 6 explores the meaning of the three Super-Ordinate Themes that emerged from the IPA, set in context by quotations from each of the participants. The Super-Ordinate Themes are also analysed in the light of literature introduced in Chapter 2. The main outcome of the study is a theory of practice referred to as a hermeneutic model of cranial osteopathy. This chapter explores the emergence of this model and situates it within phenomenological, enactivist and osteopathic theoretical traditions. The chapter concludes with a critique of the study and a review of researcher reflexivity, fore-structure and phenomenological reduction.

Chapter 7 is the concluding chapter. It considers the implications of the study for osteopathic and other healthcare research and for osteopathic practice, particularly the practice of cranial osteopathy.

CHAPTER 2: LITERATURE REVIEW

2.1. Scope, Purpose and Method of the Literature Review

As I explain, below, within the Methodology and Discussion chapters, I initially planned to conduct a meta-narrative literature review about cranial osteopathy to give context to the primary research project. A meta-narrative literature review is an innovative way of combining appropriate discipline-specific rigour in analysing complex phenomena in the fields of health and medicine that have been studied and written about by scholars and researchers from different academic fields (Gough, 2013). In the case of cranial osteopathy – amongst other complementary and alternative medicines/therapies (sometimes abbreviated to CAMs) – a meta-narrative literature review would have taken a systematic and cross-disciplinary approach to considering the highest-quality historic and contemporary literature that addressed it as a complementary therapeutic approach, investigating its safety, effectiveness and mechanism of action. It would also have addressed it from philosophical, sociological and anthropological angles. The meta-narrative literature review contributes towards understanding 'evidence' from different epistemological positions and is recommended as a way of enhancing the reach and relevance of evidence-based medicine (Greenhalgh *et al.*, 2009; Greenhalgh *et al.*, 2011).

I made the decision, based on time- and resource-constraints, to defer the conduct of a formal meta-narrative literature review until the future. This means that the review of the literature and theory that follows is introductory, selective and evaluative, rather than systematic. I have maintained the principles of the meta-narrative literature review in

examining literature about the phenomenon of cranial osteopathy that originates in different academic fields. I explore:

- Western biomedical critiques of cranial osteopathy.
- Placebo and the idea of 'meaning' in therapy (Moerman and Jonas, 2002), and the concept of 'contextual effects of therapy' (Newell, Lothe and Raven, 2017).
- Selective sociological and anthropological perspectives on cranial osteopathy, amongst other CAMs.
- Sense-making as a function of seeking healthcare, from the philosophical perspectives of phenomenology, enactivism and the subjective aesthetic experience of meaning.
- A hermeneutic model of medicine, and the concept of the 'fusion of horizons of understanding' (Svenaeus 2000a, 2000b and 2003).
- Therapeutic touch, from a neuroscientific perspective.

I begin the literature review with a brief introduction to osteopathy and an overview of cranial osteopathy. Since osteopathy originated in the north American mid-west during the nineteenth century, and cranial osteopathy likewise originated in north America during the early twentieth century, some of the literature I survey relates to osteopathic medicine (as it is known in north America). Osteopathy and cranial osteopathy are also practised widely throughout Europe and Australasia, and I occasionally refer to pertinent literature originating in these regions. Most of the literature I survey, however, relates to the practice

of osteopathy and cranial osteopathy (and of other CAMs) in the UK. Most of the literature was published in English, either originally or in translation. I do introduce some philosophical terms in their original German and French, but I always supply their common English translations.

2.2. Osteopathy and Cranial Osteopathy

2.2.1. Introduction

Cranial osteopathy is a multi-faceted phenomenon within the domain of western healthcare practice. In common with other osteopathic, complementary and orthodox medical approaches, it is "incompletely understood" (Sergueef *et al.*, 2011, p. 10). It may be legally defined as a diagnostic and treatment modality employed by osteopathic physicians (in the USA), osteopaths (in the UK and other countries where it has regulatory status) and osteopathic practitioners (in the parts of the world where it is practised but not regulated) (Osteopathic International Alliance, 2013). In professional ontological terms, it may be considered an osteopathic specialism, derived from osteopathy, but with its own codes, expertise and training pathway. Defined by proponents of western biomedicine, and more recently by those who promote a form of medical practice known as Evidence-Based Medicine (EBM), cranial osteopathy can be considered a 'complementary' or 'alternative' form of therapy, lacking evidence of its safety or effectiveness (McGrath, 2015). To its internal and external critics, cranial osteopathy is an implausible, pseudoscientific system of manual therapy on the fringe of osteopathic medicine (Singh and Ernst, 2008), which itself still has some way to go to gain legitimacy as an autonomous healthcare profession (Baer, 1981, 1984; Lee-Treweek, 2001, 2002; Singh and Ernst, 2008). In this section, I present

cranial osteopathy from a number of perspectives that help to contextualise it as a field of enquiry in which the current study is situated.

2.2.2. Osteopathy

Osteopathy is a primary health profession which originated as a system of holistic medicine in the mid-west of the USA towards the end of the nineteenth century, founded by frontiersman, Andrew Taylor Still (1828-1917). Its origins were in bone-setting, folk medicine, vitalism and the belief that healing occurs according to the laws of nature (Lewis, 2012). During the early twentieth century, osteopathic schools in the USA were reformed, bringing their curricula and standards into alignment with orthodox medical education (Flexner, 1910; Miller, 1998; Gimpel, 2007). There are currently around 82,500 osteopaths in the USA, where osteopaths must have a medical license to practice (Osteopathic International Alliance, 2013). They account for around 7% of physicians in the USA (*ibid*.). In the UK, Europe, Australasia and other parts of the world, osteopathy is a profession considered complementary or alternative to orthodox medicine, i.e. western biomedicine. Its regulatory status is dependent on the regulatory framework of medicine and healthcare practice in individual countries, but, in the UK, the passage of an Act of Parliament (*The Osteopaths Act, 1993*) gave osteopathy statutory regulation. Additionally, since 2017, osteopathy has been deemed an 'allied health profession' in the UK, meaning that osteopaths are considered to have a role to play in the delivery of national healthcare goals, and that the profession comes under the purview of the chief allied health professions officer of the NHS (NHS, 2017).

There are currently 5,353 registered osteopaths in the UK (General Osteopathic Council, 2019b), mostly operating in private practice. According to the Institute of Osteopathy (IO), a professional membership organisation for UK osteopaths, osteopathy is "a gentle and effective hands-on approach to healthcare, based on the principle that the way your body moves influences how it functions" (Institute of Osteopathy, no date a). The University College of Osteopathy (UCO), the largest osteopathic education and training provider in the UK, defines osteopathy as "a person-centred manual therapy that aims to enable patients to respond and adapt to changing circumstances and to live well" (University College of Osteopathy, no date a). These contemporary definitions represent an evolution away from osteopathy's holistic and bone-setting roots and emphasise function, health and the individuality of the osteopathic patient. According to a global survey undertaken by the Osteopathic International Alliance (OIA) (Osteopathic International Alliance, 2013), more than half of osteopathic patients are seeking help with short-term (acute) or persistent (chronic) pain affecting the back, neck and pelvis.

2.2.3. Cranial osteopathy

Some osteopaths have chosen to incorporate into their practice or to specialise in a form of osteopathy known variously as 'cranial osteopathy', 'osteopathy in the cranial field', or 'the involuntary mechanism'. According to the Sutherland Cranial College of Osteopathy (SCCO; the largest post-graduate cranial osteopathic educator and training provider in the UK), cranial osteopathy

> "is not different to osteopathy, it is the name given to a subtle and refined approach to osteopathy that follows all the principles of osteopathy, and it is used throughout the body not just in the head. The name cranial osteopathy simply refers to the fact that it includes structures inside the head".
>
> Sutherland Cranial College of Osteopathy (no date).

Where cranial osteopathy differs from osteopathy, the SCCO goes on to imply, is in the use of "a highly developed sense of touch to feel subtle changes of tension and tissue quality in the living anatomy of the whole body, and to diagnose areas of strain or dysfunction" (*ibid*.). This "highly developed sense of touch" is an arguably meaningful point of difference between cranial osteopathy and regular osteopathy, which, according to the UCO, involves "physical manipulation of the musculoskeletal system" alongside education and advice on exercise, diet and lifestyle (University College of Osteopathy, no date b), or, in the description of the IO, involves "a combination of movement, stretching, targeted deep tissue massage and manipulation of a person's muscles and joints" (Institute of Osteopathy, no date b). The "highly developed sense of touch" – also known as 'palpation' or 'manual listening' (Stuart, 2016) is explored further within the literature review, below.

Therapeutic touch (whether social, diagnostic, treatment-oriented or palliative) is utilised relatively rarely in orthodox western medical contexts but more often in the disciplines of physiotherapy and manual, complementary and alternative therapies, particularly those using 'bodywork' (Kelly *et al.*, 2017). It is not quite true to say that cranial osteopathic

practice is distinct in its use of hands-on assessment and treatment modalities, but it is in the minority, perhaps only sharing apparent similarities with the touch used in cranio-sacral therapy (CST), Reiki or polarity therapy.[4] The quality of cranial osteopathic touch, as explained in the literature review, is light in force (often below 1 N/cm^2, according to Zegarra-Parodi *et al.*, 2009), relatively static, yet far from inert. The hands of the osteopath might be in light contact with one part of the patient's body for several minutes at a time, apparently unmoving. Sometimes, the osteopath places their hand or hands beneath the patient's feet, pelvis, back or head, with a receptive intentionality that is known as "cradling" (Nathan, 1999, p. 13), for several minutes at a time.

Cranial osteopathy emerged in the USA in the early twentieth-century when osteopath, William Garner Sutherland (1873-1954), developed a physiological model of diagnosis and treatment known as the 'primary respiratory mechanism' (PRM) (Jordan, 2009). The PRM was thought to be a body-wide phenomenon of rhythmic, cellular motility within the nervous system, associated with – and possibly caused by – the fluctuation of the cerebrospinal fluid (CSF), accommodated by the articular mobility of the bones of the cranium and of the sacrum between the iliac surfaces of the innominate (pelvic) bones, whose forces were integrated by the reciprocal-tension structure of the meninges and their associated membranous attachments. The mechanism of the PRM is a speculative construct. It informs the educational framework of the SCCO and other teaching

[4] The difference, I propose, being not so much in the superficial manner of the touch, but in what it is that the toucher knows; 'knowing hands' – to reference Consedine, Standen and Niven (2016) – will bring forth a meaning that is specific to the knowledge of the toucher.

programmes (Gabutti and Draper-Rodi, 2014), yet scientific evidence of its plausibility remains lacking, despite attempts to establish its biological basis and to assess the diagnostic reliability of cranial osteopaths' palpatory assessment of a purported indicator of the PRM – the 'cranial rhythmic impulse' (Hartman and Norton, 2002; McGrath 2015). Cranial osteopathy has provoked scepticism from within the osteopathic community (Hartman and Norton, 2002; Hartman, 2005; Hartman, 2006a; McGrath, 2015) and – even amongst those who are inclined tentatively to accept its premise – there is disagreement about whether it represents a distinctive therapeutic approach, or merely a set of manipulative techniques that may be selected from the osteopathic tool-box (Zegarra-Parodi and Cerritelli, 2016).

To an uninformed observer, a cranial osteopathic treatment may make little sense and may not accord with the common stereotype of the osteopath as manipulator of the musculoskeletal system (University College of Osteopathy, no date b). In an ethnographic study exploring the phenomenon of patient trust in complementary medicine, Lee-Treweek (2002) observed a series of cranial osteopathic encounters in a Scottish osteopathic practice in 1997 and summarised the treatment approach thus:

> "a small number of osteopaths work entirely with this body system [the PRM], using very gentle, often imperceptible, movements. It is a form of treatment which demands the osteopath pay close attention to the patient's body and 'sense' the PRM movement and any restrictions in it. Whereas regular osteopaths may use very noisy and actively interventionist

> forms of physical treatment (for instance in high velocity thrusts, which are often accompanied by a click or crack from within the spine), the cranial osteopath's work can involve very indirect pressure upon the body"
>
> Lee-Treweek (2002), p. 53.

This low-velocity, indirect pressure is of very low force indeed, and, as mentioned above, is estimated to be below 1 N/cm^2, perhaps as low as 0.2 N/cm^2, although the precise measurement is difficult to establish (Zegarra-Parodi *et al.*, 2009; Seimetz, Kemper and Duma, 2012; Gabutti and Draper-Rodi, 2014; Cerritelli *et al.*, 2017). To put this in context, human tissue damage (such as bruising) can occur with sustained forces of 140 N/cm^2 (Krüger *et al.*, 2016) and the forces involved in spinal manipulation have been measured at 100-500 N, delivered at high velocity (200 ms) (Kawchuk *et al.*, 1992; Conway *et al.*, 1993; Herzog, 2010).

There are few published accounts that describe – in detail – what cranial osteopaths are experiencing or aiming to achieve when they work with this feather-light touch. The renowned osteopath, Rollin Becker, admits that it is very difficult to describe what it is that cranial osteopaths do, but describes cultivating an attitude of empathetic sharing, in the manner of Carl Rogers, and then learning to use a "skillful sense of touch to allow health to be restored" (Becker, 1997, p. 14). He describes a manner of "silently listening to and understanding the body physiology" of the patient with hands placed carefully upon them (*ibid*., p. 14). He uses a curious metaphor next: "[we] work with it, and tease it until we realize that the body physiology of the patient is making some kind of response towards

health" (*ibid*., p. 14). He continues with the idea that the patient will have a sense "that health is being shared" (*ibid*., p. 15).

The French osteopath, Emmanuelle Roche, echoes Becker in describing a palpatory perception, 'osteopathic manual listening', in which the osteopath perceives with their whole sensorium the living physiology of the patient. The osteopath 'listens', 'attends' and 'observes' the interior of their patient – through a light palpatory contact – both the harmonious and discordant rhythms of the micro-movements that animate the patient's whole body, such as "la croissance des cheveux, l'intérieur des viscères, le jeu des systems musculo-nerveuex et intraveineux"[5] (Gens et Roche, 2014, p. 5).

Neither the ethnographic observations of Lee-Treweek (2002), nor the insights of cranial osteopaths who use either matter-of-fact or poetic language to describe the method of cranial osteopathic practice convey much understanding to the lay person seeking to learn about cranial osteopathy. It may seem surprising, then, to know that cranial osteopathy seems to be popular with patients and practitioners. A recent global study suggests that cranial osteopathy is the most commonly provided type of osteopathic treatment – although the description of the methods used to collect these data and draw these conclusions may not have been sufficiently detailed, according to McGrath (2015). A more robust, though small-scale, standardised data-collection survey study of UK osteopaths, conducted in 2009, found that cranial osteopathy was reportedly used by osteopaths in a

[5] "the growth of the hair, the interior of the organs, the play of the neuro-muscular and intravenous systems".

quarter of treatment sessions with patients (Fawkes *et al.*, 2014). It is currently thought that there are 30,000 osteopathic consultation and treatment appointments every working day in the UK (General Osteopathic Council, 2006), and, if these figures are reliable, it is possible to speculate that around 7,500 sessions involving cranial osteopathy take place in the UK every day – around 2 million consultations per year.[6] A standardised data-collection survey study of UK cranial osteopaths affiliated with the SCCO undertaken in 2011/2012 (for which 530 patient questionnaires were completed) found that 63 per cent of adults attending for new instances of cranial osteopathic treatment were female (whereas 63 per cent of infants and babies attending were male), and that the age of patients ranged between one week and 89 years, with a mean of 40.3 years (Wilkinson *et al.*, 2015). Babies and infants constituted 14.7 per cent of the patient demographic, and 10 per cent were over the age of 70. The study found that two-thirds of patients attended because of musculoskeletal pain or stiffness, 13 per cent of the consultations were recorded as relating to 'unsettled baby/infantile colic', and other presenting problems were categorised as relating to fatigue, digestive symptoms, respiratory symptoms, ear-ache and tinnitus, dizziness and vertigo (Wilkinson *et al.*, 2015).

Few studies have explored the reasons that people choose to consult a cranial osteopath. As part of their standardised data-collection survey of cranial osteopathy patients, Wilkinson *et al.* (2015, p. 16) found that 48 per cent of their 530 cranial osteopathic patient responders

[6] This is an unverified extrapolation of the figures arising from two robust studies: Fawkes *et al.* (2014) and General Osteopathic Council (2006).

declared that they had followed a personal recommendation to try cranial osteopathy and 13.5 per cent of the responders indicated that they had been “seeking gentle treatment”. Beyond this, there has been no in-depth examination of the popularity of cranial osteopathy. The answers may lie in the popularity of the loose classification of therapies known as ‘complementary and alternative medicine’ (CAM), which was defined by the UK House of Lords Science and Technology Committee as “a diverse group of health-related therapies and disciplines which are not considered to be a part of mainstream medical care” (Parliament. House of Lords, 2000).

2.2.4. Complementary and alternative medicine (CAM)

In the UK, and regulated though it is, osteopathy is considered to be a CAM by the National Health Service (NHS, 2016). The distinction between ‘complementary’ and ‘alternative’ is problematic (Ross, 2012a), although their synonymity is now often presumed (Stoneman, Sturgis and Allum, 2012; Sheppard, 2015). ‘Complementary’ has the ring of accommodation to the paradigm of western orthodox medicine; ‘alternative’ contains within it the notion of a distinct and separate paradigm (Ning, 2012). In the process of its professionalisation in the UK, osteopathy has had to define its position on the complementary-alternative spectrum, resulting in tension – and even factionalism – between its ‘scientific’ and ‘purist’ traditions (Grundy and Vogel, 2005), as discussed below.

The reasons that people seek CAM care have been examined through literature reviews and survey studies based on the experiences of European and North American populations. The themes that emerge are the perception that CAMs offer compassionate and humane care

(Heusser *et al.*, 2012) and a warm and caring therapeutic relationship with practitioners (Luff and Thomas, 2000). Another theme is dissatisfaction and a sense of alienation in the face of systems of care within mainstream medicine that are considered impersonal, iatrogenic and reductionist (Stoneman, Sturgis and Allum, 2012). Tyreman (2011, p. 216) suggests that, facing illness, patients need "warmth, comfort and reassurance", whereas these values are repudiated by orthodox medicine's scientific ethos, which is "objective, value-free, impartial and so on". Sointu (2013) analysed in-depth interviews with 44 UK CAM patients and found that individuals were drawn to CAM because of the explicitly holistic experiences they promote, involving a "positive coding" of the body, a positive experience of touch and a positive awareness of the healing process (Sointu, 2013, p. 542). It is possible that these analyses have relevance for cranial osteopathy, as the literature on patients' experience of cranial osteopathy, reviewed below, suggests.

Lee-Treweek (2002) investigated the phenomenon of public trust in complementary therapies from a sociological perspective, in an ethnographic study of a cranial osteopathic clinic in Scotland. Citing Giddens (1990), Lee-Treweek (2002) explored the trust that is required to navigate and negotiate our complex late-modern cultural environment. On a day spent observing the work of a cranial osteopath with sixteen individuals who were returning for treatment, she notes that "[p]atients would refer to their experience in treatment as deeply relaxing and the majority reported that they could not detect anything was happening" (Lee-Treweek, 2002, p. 54). She interviewed the patients after their treatment and noted that they were trustful of the work of the osteopath, even though they experienced little of note during treatment, and their progress in gaining relief from

symptoms was slow. She noted that their trust seemed to be rooted in respect for the expertise they attributed to their cranial osteopath and concluded that the patients generated further trust by undertaking phenomenological work as part of the therapeutic process of cranial osteopathy, as well as deliberating how it accorded with their values and beliefs about health.

A more recent study, with a quantitative design, conducted in a different environment, generated results that point to a contrast with those of Lee-Treweek (2002). A standardised patient-perception study of 42 adults attending for cranial osteopathy across Australia and New Zealand found that all reported having experienced benefit from attending a mean of 4.43 sessions (Mulcahy and Vaughan, 2014). The patient perception measure had been developed and tested for face validity and contained items about efficacy and satisfaction with treatment, sensory perceptions of treatment, the therapeutic relationship, emotion and mood treatment effects and cognition treatment effects (Mulcahy *et al.*, 2013). The items on a pre-determined list of intra-treatment 'sensations' most commonly selected were 'relaxed' (83.3 per cent), 'releasing' (73.8 per cent), 'unwinding' (57.1 per cent), 'warmth' (45.2 per cent), 'softening' (40.5 per cent) and 'balancing' (40.5 per cent) (Mulcahy and Vaughan, 2014), in contrast with the participants in the ethnographic study outlined above (Lee-Treweek, 2002). The authors claim that these sensations suggest a favourable experience and claim that they were associated with an improvement in symptoms and an increase in their sense of well-being, whilst acknowledging that the patient-perception measure requires further validity-testing.

There have, to my knowledge, been no other published studies exploring the experience of patients of cranial osteopathy, specifically. Orrock (2016) explored the lived experience of patients of osteopathy in Australia, using a mixed-method qualitative design, combining a survey (to which 161 patients responded with completed questionnaires) and descriptive phenomenological analysis of the interview transcripts of a sub-set of 11 of the survey-responders. It is not stated whether any of the participants had received cranial osteopathic treatment. The meta-themes to have arisen from the study were 'patient decision making', 'patient shared experiences of the osteopathic encounter', 'tailored patient-centred care', 'therapeutic relationship in healthcare'. Orrock (2016, p. 133) presents an account of the experience of the participants suggestive of patient-focused practice in which care is taken to inform, educate and enable people consulting osteopaths. However, the study does not report on the participants' lived experience of therapeutic touch or any experiences of embodiment.

There has also been a recent thematic analysis by Brough *et al.* (2015) of the perceptions of 29 users of CST, a CAM modality derived from osteopathic theory and practice, that is taught to and practised by unregulated complementary or alternative therapists (Ernst, 2012). The participants were found to have reported benefits to their body, mind and spirit, and to have experienced an enhanced awareness of the link between their mind and their body. They were also found to have highlighted the positive, caring nature of the therapeutic relationship with their cranio-sacral therapist, as well as "changes in perceptual awareness, of seeing colours and images and new sensations in the body" (Brough *et al.*, 2015, p. 178).

The authors identified that some participants reported “greater awareness of mind-body links” (*ibid*., p. 176) following CST and others benefited from support for their “spiritual development” (*ibid*., p. 177). They explored possible mechanisms for these reported improvements and proposed two potential theories that had emerged from their data analysis. The first was the role of the therapeutic relationship and the second was the alteration in the patients’ perception of their body, senses and environment. The first theory is illustrated by participant quotations concerning the value of collaborating with a practitioner in a nurturing relationship and therapeutic ambience, as well as feeling listened to. The second theory is illustrated by participant quotations about altered perceptual and embodied awareness, such as feeling relaxed to the point of “being asleep but still awake” (*ibid*., p. 178), becoming aware of seeing colours, feeling a “firework fountain” travelling up through the spine (*ibid*., p. 178). The authors suggest that this perceptual alteration might be operative through the facilitation of greater self-awareness amongst the study’s participants, a theme also found in the study described below by Elden, Lundgren and Robertson (2014).

Elden, Lundgren and Robertson (2014) used content analysis to interpret the experience of pregnant women with pelvic girdle pain who received five sessions of CST delivered by experienced practitioners. The authors report a range of responses to the treatment modality, from scepticism to pleasure. They quote examples of the participants reporting pain-relief and relaxation, but more than this too: “as if they had reached equilibrium. They said it felt their bodies exhaled with relief” (Elden, Lundgren and Robertson, 2014, p. 3). The authors explore putative mechanisms underlying the experience of the participants,

including greater awareness of their body posture, the pleasure induced by light therapeutic touch and pain-acceptance. The authors do not explore the metaphor of bodies exhaling with relief, and how this experience might have arisen, a point I return to in the Findings and Discussion chapters of the current study.

Wenham *et al.* (2018) present the findings of a mixed-methods, longitudinal study into the effects and experience of Alexander Technique (AT) (a system of postural re-education) and acupuncture in a population of patients with persistent neck pain. The qualitative aspect of their study was based on a grounded-theory analysis of participants' reports of their experience. Not every participant was reported to have benefited from AT or acupuncture, but those who did were considered to have benefited from developing self-awareness, skills, knowledge and self-efficacy. A key factor was identified as the positive, therapeutic relationship that participants had developed with their practitioners. The authors identified a further potential mechanism of effectiveness – the transformative development of the sense of embodiment in some participants. Although the theme of embodiment is not explored in great depth, some factors thought to have played a part for several of the study's participants were the reported development of a sense of bodily integration and interconnectedness and a renewed appreciation of a sense of self.

Whatley, Street and Kay (2018) report on a mixed methods study of the outcomes and experience of participants with upper limb lymphoedema following breast cancer, who were given treatment by a reflexologist. Reflexology is a hands-on complementary therapy involving massage of the feet, and is often used by patients with cancer, according to the

authors of the study. Reflexology has a putative physiological mechanism that is as contested as that of cranial osteopathy and CST although the authors do not acknowledge its disputed plausibility. The qualitative aspect of the study was based on a content analysis of the participants' reports of their experience of lymphoedema and of reflexology. Some participants reported an improvement in their symptoms, despite initial scepticism about the plausibility of the therapy. They also reported feelings of optimism and a return to activity and work. The illustration of the physical and sensory experience of reflexology is surprisingly muted, particularly considering the significant reduction in arm volume reported by the authors in the quantitative paper (Whatley *et al.* (2016)) that accompanies Whatley, Street and Kay (2018). One participant is quoted as reporting "a sort of rippling effect in my arm, sort of little ripples down" (*ibid*., p. 127) and another as experiencing "something moving in my arm" (*ibid*., p. 127). The authors of the report do not comment on the therapeutic mechanism of reflexology, and seem to take its effectiveness at face value.

The authors of the four papers analysed above suggest that their studies might contribute towards a deeper understanding of the mechanism of the respective therapies (Brough *et al.*, 2015; Elden, Lundgren and Robertson, 2014; Wenham *et al.*, 2018; Whatley, Street and Kay, 2018) and highlight factors such as the importance of the therapeutic relationship and a positive enhancement of a sense of self, both in the domains of efficacy or embodiment. The authors do not, however – at least in the papers resulting from their studies – engage deeply with how these themes might contribute to our understanding of therapeutic mechanisms, nor make the case that a re-evaluation of the role of the mechanism might contribute to a change in the design of the study, in order to take account of the relevant

factors at play. The authors fail to explore the themes of therapeutic relationship and sense of self in the light of current theoretical thinking about the contextual effects of healthcare or the senses of self that are to do with agency, embodiment, the body-schema and body-image. Neither do they dwell on the mechanisms underpinning therapeutic touch. I address these questions below in the section of the current chapter on embodied and enactive sense-making.

2.2.5. Western biomedical critique of cranial osteopathy

I now explore the western biomedical critique of cranial osteopathy as a healthcare practice, particularly in the light of the standards of evidence-based medicine (EBM) and debates about the plausibility of its mechanism of effect.

From the positivist epistemological stand-point of EBM, it is highly problematic to offer therapeutic interventions that have little evidence of efficacy and particularly whose mechanisms of effect are implausible (Singh, no date). The most recently published systematic reviews evaluating the diagnostic reliability and clinical effectiveness of cranial osteopathy (Jäkel and von Hauenschild, 2011; Gillaud *et al.*, 2016) found that the methodologically sound papers that met the inclusion criteria were so sparse and heterogeneous as to make it impossible to draw conclusions about its safety and effectiveness. It is no surprise, then, that critics of cranial osteopathy seek explanations for its mechanism and campaign against its provision within the NHS (Skeptic Barista, 2011; Barrett, 2012; Mohammadi, 2015).

Cranial osteopathy is often described as ‘subtle’ (Hamm, 2011) and ‘gentle’ (Lee-Treweek, 2002). Its methods and mechanism of effect are contentious (Hartman, 2006a), and there is much discussion of the plausibility of the so-called ‘Primary Respiratory Mechanism’ (PRM), the theoretical anatomico-physiological construct developed by the osteopath, W.G. Sutherland (Sutherland, 1944). The PRM has been construed as a method of cellular respiration, involving the involuntary fluctuation of fluid within the nervous system, and is sometimes referred to as the ‘Breath of Life’ (McPartland and Skinner, 2005). Sutherland and his pupils employed metaphorical language to describe the ‘intelligence’ and ‘potency’ of the ‘Living Mechanism’ (Becker, 1997; Sutherland, 1990). Mulcahy and Vaughan (2014, p. 235) note that its mechanism “cannot readily be measured by observers or accessed via organic measures of change such as pathology or radiology”. Handoll (2000) investigated the theory that the phenomenon of ‘potency’ could be explained by quantum mechanics, but there have been no investigations that have given this notion credence. O’Brien (2013) suggests a metaphysical model based on a psychological relationship between the osteopath and the patient of cranial osteopathy. He describes it as,

> “a subtle, variable form of communication between two persons, the practitioner and client. The practitioner uses his own stillness as a neutral force, transferring this tranquillity via a possible trance-like state dynamically to the client. It is postulated that this allows the client to benefit from an opening-up experience, a broadening of their cognitive scope”
>
> O’Brien (2013), p. 112.

This speculative model, replete with abstract, metaphysical concepts, such as 'stillness', 'neutral force', 'tranquillity' and 'opening-up' is interesting in the way that it foregrounds the relationship between the patient and the practitioner and departs from the biomechanical explanations that have traditionally been used to explain osteopathic treatment.

Other explanatory models that attempt to explain the phenomenon of the PRM include central nervous system motility; glial cell pulsation; central nervous system pressurestat hydraulics; polyrhythms generated by a combination of cerebro-spinal fluid fluctuation and vascular pulsations; Traube-Hering-Mayer wave oscillations within blood pressure (all summarised by Ferguson *et al.* (1998)); accommodative shape change within the superior orbital fissures (Cook, 2005); variations in the electromagnetic charge within the patient's extra-cellular matrix (Hamm, 2011), and muscular activation of cranial bone deflection (Gabutti and Draper-Rodi, 2014). These theories are speculative, and there has been no systematic attempt to design studies that could test them. To McGrath (2015, p. 136), they represent cranial osteopathy's unfalsifiability, and he asks, "In the event that the 'primary respiratory mechanism' is unequivocally identified with scientific rigour the bigger question still remains, 'so what?' What if any, is the relationship between OCF [cranial osteopathy] to the aetiology of a disease, to its subsequent diagnosis and to its treatment?" Evidence that would satisfy the positivist criteria of EBM – and therefore propose an answer to this question – is lacking from the osteopathic, medical and CAM-based literature. It is therefore instructive to consider critical perspectives from beyond the disciplinary realm of medicine and CAM to gain insight into aspects of the debates outlined above.

2.2.6. Placebo, meaning and the contextual effects of therapy

The mechanism of cranial osteopathy has been dismissed by critics (including critics who are osteopaths) as nothing more than the 'placebo effect' (Hartman, 2006a; McGrath, 2015). It is important work for those who wish to reform EBM (Epstein, 2014; Godlee, 2014; Greenhalgh, Howick and Maskrey, 2014; Spence, 2014; Greenhalgh *et al.*, 2015; Kelly *et al.*, 2015;) to question the thinking that continues to maintain the legitimacy of the concept of 'placebo' as shorthand for 'quackery'. In 2002 and 2003, Moerman and Jonas began this work, publishing two papers proposing a recontextualisation of the clinical-trial concept of the 'placebo-effect', which, they claimed, had become "inevitably mixed with some sense of magic, legerdemain, and, most seriously, trickery or sham" (Moerman, 2003, unpaginated).

Moerman and Jonas (2002) challenged the notion that 'regression to the mean' (a statistical concept that in this context stands for the natural resolution of symptoms through the course of time) was an effect that only pertained to the placebo arms of clinical trials, pointing out that patients in different arms of trials were as likely as each other to get better regardless of whether they had been treated with an active or an inert substance. They proposed instead that the 'placebo-effect' should be viewed as a 'meaning response', i.e. "the physiologic or psychological effects of meaning in the origins or treatment of illness" (Moerman and Jonas, 2002, p. 472). They went on to give examples of the way that "meaning permeates medical treatment", from the "costume" of the doctor, to their style of communication, to the language that they use (Moerman and Jonas, 2002, p. 473). Their argument stopped short of developing a new paradigm for therapeutic semiosis and semantology, and has failed to gain full acceptance (Gorski, 2011).

Despite this, the arguments proposed by Moerman and Jonas (2002) have influenced the discourse about the 'placebo-effect'. Reviewing the use of placebo interventions in clinical trials, and citing the aforementioned authors, Gupta and Verma (2013, p. 49) demonstrate that the consensus about placebo has become more nuanced as its constituent mechanisms have been studied in greater depth. They make the argument that there are many mechanisms underlying the role of placebo, including psychological mechanisms, such as "expectations, conditioning, learning, memory, motivation, somatic focus, reward and reduction of anxiety", and neurobiological mechanisms, such as endogenous opioid analgesia, as well as analgesia that is mediated through the inhibition of the peptide, cholecystokinin. Despite this understanding, it is still common to use the term, 'placebo', as a means of invalidating therapeutic approaches such as cranial osteopathy, that lie outside the orthodox medical paradigm (Hartman, 2006a; McGrath, 2015).

In the UK, the profession of chiropractic has faced similar criticisms that it peddles placebo (Ernst, 2015; Mohammadi, 2015). In a recent paper, Newell, Lothe and Raven (2017) have confronted these criticisms with a model that locates the mechanism of chiropractic within the interplay between so-called "contextual effects" (*ibid*., p. 1) or "contextual factors" (*ibid*., p. 3) and what they call "innate healing" (*ibid*., p. 1). They list some previously studied contextual factors, such as verbal and non-verbal communication within the patient-practitioner relationship; the benefit of having a clear diagnosis; a patient-centred approach; therapeutic touch; and environmental factors such as clinical architecture, setting and interior design. They challenge the idea that it is ever possible to decontextualise the specific mechanism of the treatment intervention from that of these non-specific features

of healthcare, and suggests that they are both required for the activation of the forces of innate healing. They suggest that patients are unable to achieve this alone and makes reference to existing models that depend on evolutionary arguments to explain why people are unable to self-generate strong placebo effects. They conclude with the proposal that,

> "intrinsic recuperative mechanisms including pain and immune modulation can be switched on by anthropologically and evolutionary informed environmental, verbal and physical signals as delivered in a cultural context"

Newell, Lothe and Raven (2017), p. 7.

These "intrinsic recuperative mechanisms" are the physiological processes responsible for cellular repair and tissue healing, and, although it would seem likely from an evolutionary perspective that the cultural context would have an impact on the rate of physiological repair and healing – and the authors cite other theoretical papers that contribute to this idea – they make no specific reference to clinical trials that support the theory. The proposition that contextual factors support healing is something I return to in the discussion of the findings of the current study, in the Discussion chapter.

2.2.7. Sociological and anthropological contexts for understanding cranial osteopathy

Sociological and anthropological accounts of structural trends and human experiences within the field of medicine and healthcare, examined for universal commonalities and differences across time and place, help to situate the phenomenon of cranial osteopathy – in all its multi-faceted complexity – within a political, societal, historical and cultural context.

I set out a brief account of certain sociological and anthropological perspectives that have pertinence to the current study. The first is the sociological model of power-play and 'boundary work' undertaken by members of a profession as it manoeuvres to sustain or build its reputation. The second is the problematisation of the role of hands-on bodywork within physiotherapy – an argument that has resonances with the case of cranial osteopathy, particularly its valorisation of a "highly developed sense of touch" (SCCO, no date). Thirdly, I turn to an anthropological account of the phenomenon of 'illocutionary force', the concept used by the anthropologist, Stanley Tambiah (1929-2014), to denote the operative symbolic potency which imbues ritualistic acts with meaning.

The intra-professional debates about cranial osteopathy that have been recorded in the pages of the *International Journal of Osteopathic Medicine* in the past few decades (Hartman, 2006a; Maddick and Korth, 2006; Hartman, 2006b; Maddick, 2007; McGrath, 2015; King, 2016; Zegarra-Parodi and Cerritelli, 2016; Monro *et al.*, 2017) can be understood as the 'boundary work' demarcating the values of one group from those of another when a profession is jostling for assimilation into the mainstream (Villanueva-Russell, 2011), as osteopathy has done recently (Osteopathic International Alliance, 2013). The debates have centred on the deficit of evidence to explain the primary respiratory mechanism, its role as 'teaching metaphor', 'belief system', 'placebo' (Hartman, 2006a), its status as 'enigmatic' (Zegarra-Parodi and Cerritelli, 2016, p. 1) and an 'unfalsifiable belief' (McGrath, 2015, p. 136). There have been no academic studies exploring the professional ontology of osteopathy since Baer (1981) and Baer (1984, p. 717) assessed the "drive for professionalization in British osteopathy", Miller (1998) presented a sociological case

analysis of the evolution of the identity of osteopaths in the USA, and Lee-Treweek (2001, 2002) published two sociological examinations of osteopathic practice in the UK at the time that osteopaths had just achieved regulated practitioner status. A more recent comparable study has been published by Villanueva-Russell (2011), who describes the processes experienced by Canadian acupuncturists seeking state regulation. She found that the internecine debates between the Traditional Chinese Medicine practitioners and the western medical acupuncturists featured a dialectic of ideological purity, on the one hand, and scientific rigour, on the other. This type of rhetorical 'boundary work' echoes the recent debates between sceptical, regular osteopaths and cranial osteopaths described above.

The sociological lens used by Moffatt and Kerry (2018, p. 175) to critique the phenomenon of touch within physiotherapy as a "consumer health technology" can be applied equally to cranial osteopathy, which, as previously mentioned, is purported to use a "highly developed sense of touch to feel subtle changes of tension and tissue quality in the living anatomy of the whole body" (SCCO, no date). Within this interpretation, physiotherapy (as is the case with other therapies, such as cranial osteopathy) is viewed as a form of bodywork, or, in the words of Twigg *et al.* (2011, p. 171) whom they quote, "paid work on the bodies of others". They go on to draw a circuitous association between therapeutic touch, massage and sex-work and ask the questions,

> "Do we acquiesce to this modern consumerism and provide touch as a service despite empirical research findings that contest its therapeutic effectiveness (what we will call "scientific evidence")? Or do we abandon

> touch on the grounds of such “evidence”, and in doing so risk alienating ourselves from the consumerist public?”
>
> Moffatt and Kerry (2018), pp. 175-176.

They adopt a Foucauldian view of late-modernity in which it becomes the duty of the citizen to adapt to the prevailing discourse about health, responsibility, self-discipline and the consumption of markers of a healthy life-style, such as investing in the body-project. Therapeutic touch, in this account, becomes a commodity, with the embedded association that it may “confer a symbolic status for the consumer” (*ibid*. p. 184). Their argument leans towards abjuring the use of therapeutic touch within physiotherapy on this very ground, and with the added argument that the current orthodox biomedical evidence-base does not support its use. However, they conclude with a pragmatic compromise, recommending that physiotherapeutic touch be retained as a treatment modality, but only alongside the prescription of facilitated self-management programmes.

Despite the authors’ reference of Merleau-Ponty, the argument is weakened by the failure of the authors to consider more deeply the universal human, cultural – and, indeed, evolutionary – imperative towards touch, which is considered in anthropological accounts of medicine and healthcare (such as the account by Rasmussen (2006) of Tuareg medicine women who ‘diagnose’ and ‘treat’ through touch and massage – although the apostrophised words here are inadequate translations of the Tuareg meanings). The example of an anthropological perspective, which follows below, brings another perspective to understanding the ‘enigma’ of cranial osteopathy.

In an influential reframing of the 'form and meaning of magical acts', Tambiah (1973/2017) explored the operative power of incantatory speech in the ritual of magic, and identified the performative force of the *act* of speech (rather than merely its *content*, citing the work of ordinary language philosopher, J.L. Austin, on speech act theory) as instrumental in the generation of magical potency. Tambiah claimed that,

> "[m]agical acts are ritual acts, and ritual acts are in turn performative acts whose positive and creative meaning is missed and whose persuasive validity is misjudged if they are subjected to that kind of empirical verification associated with scientific activity"
>
> Tambiah (1973/2017), p. 451.

He draws an analogy between traditions of witchcraft and magic, religious sacraments, and the rites and ceremonies of late-modernity, in which the utterance of a formulaic sentence (he gives the example of marriage vows) has both locutionary content and illocutionary force, "which simply by virtue of being enacted (under the appropriate conditions) achieve a change of state, or do something effective" (*ibid*., p. 467). Ross (2012b) concludes that Tambiah finds no conflict between the competing truths of contemporary western science and magic since they are based on different sets of principles. I do not intend to compare the competing paradigms of western biomedicine and CAMs such as cranial osteopathy with the dichotomy between western science and magic; however, the language used by critics of cranial osteopathy – 'enigma', 'belief system' – tends to suggest that its critics do just this. I return to the concept of the performativity of ritual and the illocutionary force of

speech acts later, in the Findings and Discussion chapters of this thesis, in exploring some aspects of the phenomenon of cranial osteopathy with an anthropological lens.

2.3. Sense-making

The current study is concerned with sense-making and meaning-making, and particularly the making of sense that is subjectively 'felt' and the creation of meaning that is subjectively 'experienced' (Gendlin, 1962). The phenomenon of cranial osteopathy, it will be shown, is an experience that appears to be characterised by its evocation of intense prenoetic and unverbalisable aesthetic sensations in both its practitioners and its patients. Therefore, while it is important not to side-line accounts of sense-making and meaning-making that are concerned with reflective cognition, reasoning and theory (as discussed, for example, by Smith (2018)), I focus on the developing interdisciplinary human science and philosophy of enactive cognition, which has evolved from the work of Varela, Thompson and Rosch (1991) on the embodied mind. They proposed the term, 'enactive',

> "to emphasize the growing conviction that cognition is not the representation of a pregiven world by a pregiven mind but is rather the enactment of a world and a mind on the basis of a history of the variety of actions that a being in the world performs"
>
> Varela, Thompson and Rosch (2016), p. 9.

Varela, Thompson and Rosch (1991, 2016) draw on the philosophical premises of phenomenology and the embodied cognitive linguistics and semantics of Lakoff and Johnson

(1980a) to argue against the traditional premise of cognitive science that there are divisions between the external, objectivist, 'real' world of objects, the perceiving minds of those who inhabit it, and the vehicles of their bodies.

I now give a brief introduction to phenomenology, enactivism, and theories about subjective felt experience, maintaining a particular focus on the domain of the human experience of health and healthcare, particularly as it pertains to 'enigmatic' and unorthodox complementary therapies that involve the diagnostic and therapeutic use of touch, as with cranial osteopathy.

2.3.1. Phenomenology

Phenomenology is a branch of philosophy proposed by Edmund Husserl (1859-1938), who intended to develop a new form of human and social science underpinned by a rigorous philosophical method that addressed what he saw as the over-weaning objectivism of the positive sciences (Zahavi, 2003, p. 126). Husserl's project was to understand how phenomena – such as objects, other people, thoughts, memories, dreams – appear to human consciousness. He referred to phenomena as "the things themselves" (*ibid*., p. 34) – with the emphasis being on how objects or thoughts appeared to people. Husserl viewed all 'things' – as well as the people to whom they appear – as situated in a world of direct, pre-reflective experience – what he called the *Lebenswelt* ('Lifeworld'; *ibid*., pp. 12-130). He was influenced by one of his teachers, the philosopher, Franz Brentano (1838-1917), who proposed that the ontological status of phenomena – i.e. whether phenomena actually exist in an objectivist, external 'real world' or dwell in the realm of consciousness – had no impact

on our ability to perceive them (Jacquette, 2004, pp. 98-100). Brentano described all phenomena that were capable of being perceived as 'intentional objects', with 'intentionality' being the "mark of the mental" (*ibid*., p. 10); in other words, the hallmark of human consciousness.

The concept of intentionality was developed by Husserl and took further shape in the hands of Martin Heidegger (1889-1976), who sought to re-orientate the question of *being* in meaningful being *itself* (Mulhall, 2005, pp. 8-11.) Heidegger evolved – but arguably never resolved – the ontological dilemma of phenomenology in his magnum opus, "Being and Time" (*Sein und Zeit*, originally published in 1927). His untranslatable concept of *Dasein* is thought to set the scene for a way of understanding the meaning of 'being', and in particular, the 'being' of beings, that is, human beings (Mulhall, 2005, pp. 207-213). Heidegger advanced the argument that our being is always situated in our meaningful world, and used the hyphenated formulation, 'in-der-Welt-sein', which is usually translated as 'Being-in-the-world', to develop a central premise in post-Husserlian phenomenology – that we and the world are a mutually constitutive whole. Mulhall (2005) explains this argument:

> "Heidegger thereby contests the Cartesian understanding of the human way of being as essentially compound, a synthesis of categorially distinct elements (i.e. of mind and body) in a purely material world"
>
> Mulhall (2005), p. 36.

Sheehan (2014) takes this interpretation to a distinctive conclusion, by identifying Heidegger's use of 'being' (*Sein*) with his use of 'meaning' (*Sinn* or *Bedeutung*) and argues that, by 'Being-in-the-world', Heidegger intended *In-der-Bedeutsamkeit-sein* (Sheehan, 2014, p. 260). By this, Sheehan (2014) understands that humans and the phenomena they encounter co-constitute meaningful being-in-the-meaningful-world.

The dual and related problems of our embodiment and the status of other people in our field of meaning is not satisfactorily resolved by either Husserl or Heidegger, according to Dreyfus (2000) and McMullin (2013). Husserl advanced a phenomenological account of perception as the source of all knowledge of the world (Moran, 2010) and Heidegger coined the concept of *Mitsein* ('Being-with') to illustrate how *Dasein* accommodates shared, mutual and reciprocal being, but it was Merleau-Ponty (1908-1961) who advanced the phenomenological project so that it could really take account of fleshly Being-in-the-world, as well as being-with-others. I return to the question of intersubjectivity when discussing the hermeneutic model of medicine, within the current chapter, below. What follows immediately is a brief account of Merleau-Ponty's thinking on embodied perception.

Merleau-Ponty, acknowledging his debt to Husserl (Moran, 2010) and Plessner (Krüger, 2010), made the distinction between *Leib* (the body we are, our 'lived body', or the body-as-subject) and *Körper* (the body we have, or the body-as-object). In his seminal work, "Phenomenology of Perception" (*Phénoménologie de la perception*, originally published in 1945), Merleau-Ponty (1962) asserts the 'primacy' of perception in his account of his thesis that he 'has' the world through the agency of his sensing body (1962, p. 408), developing a

model of perception that extends beyond the pre-phenomenological, empiricist and rationalist models of perception.

Although Merleau-Ponty's work references the 'primacy' of perception, his commentators have suggested that, for Merleau-Ponty, perception is actually of a piece with its counter-part, action. In the view of Gendlin (1992),

> "[i]t is clear that Merleau-Ponty meant to escape the limitations brought by beginning with perception. He meant to include (latently and implicitly) also our bodily interactional Being-in-the-world, all of our life in situations"
>
> Gendlin (1992), p. 344.

Shusterman (2008, p. 49) agrees, and also claims that Merleau-Ponty,

> "insists that the body is not only the crucial source of all perception and action but also the core of our expressive capability and thus the ground of all language and meaning"
>
> Shusterman, (2008), p. 49.

What Gendlin (1992) and Shusterman (2008) are highlighting is that Merleau-Ponty articulated a model that works as a post-Cartesian foundation for understanding an active, embodied, aesthetic immersion in our meaningful world, in which our directedness towards our environment, our projects and other people – our "posture vis-à-vis the world" (Reuter,

1999) – involves an outward-reaching multisensory grasp that engages the primacy of our body (Gendlin, 1992) rather than that of our mind. In Merleau-Ponty's model, there is a form of pre-reflective knowing that forms the 'background' to all of our reflective (conscious) knowing (Shusterman, 2012; Dreyfus and Taylor, 2015). It is this pre-reflective, embodied form of sense-making – which Merleau-Ponty (1962) refers to as 'having the world' – that informs the method, findings and discussion of the current study, and which is of special interest to scholars and researchers of the interdisciplinary field of enactivism, which I introduce briefly, below.

2.3.2. Enactivism

Enactivism is a field of enquiry which diverges from the traditional representationalist concept of cognition and instead frames consciousness as a property that emerges from the interaction between animate forms[7] and their environments (Hutto and Myin, 2012; Gallagher, 2017). It is concerned with 'biosemiotic' sense-making (Cowley, 2018) as adaptation to environmental stimuli – or, in another word, homeostasis (Thompson and Stapleton, 2009; de Jesus, 2018); as a feature of social cognition – in debates about extended minds and the biological basis of empathy (Zahavi, 2004, 2010; de Jaegher and di

[7] The term, 'animate form', is used by Sheets-Johnstone (2011, pp. 312-313) to correct what she considers to be the tautology implicit in the concept of enactivism and embodiment; she looks to simplify and de-anthropise the concept of the organism, collapsing the distinction between non-organic and organic life-forms. In her ecological account of the ontological order, any form that is capable of movement is 'animate' and obeys the principle that movement is prime. She acknowledges her debt to Aristotle's 'De anime' and von Uexküll's 'Umwelt' in her construction of 'animate form' as the class of life that is defined by its survivalist imperative to move within its environment. Throughout this thesis, I adopt the formulation, 'animate form', as a means of referring to organisms and beings that express movement.

Paolo, 2007; Colombetti, 2017; Hutto, 2017; Maiese, 2018); and as embodied negotiation of the world (Gallagher, 2005; 2017; Sheets-Johnstone, 2011; Nowakowski and Komendzínski, 2014).

Acknowledging the departure from traditional cognitive science made by theorists who advance the enactivist 'manifesto' (Thompson, n.d)., Thompson and Stapleton (2009) present a reframing of cognitivist assumptions about the division between the internal mind and the external world. They explain that the enactivist perspective begins not with the neuro-anatomy and the question of where the division falls between the internal and external components of the being and its world, but with the question of how systems are organised in order to be autonomous. They suggest that to have autonomy requires an ability to make sense of the environment, in order to respond and adapt to it. They begin with the example of a bacterium "swimming uphill in a food gradient of sugar" (*ibid*., p. 24); to the bacterium, sugar is "significant" (*ibid*., p. 24); the bacterium's ability to sense the sugar, through chemotaxis, is an example of sense-making at the most basic level: "bacteria are the simplest kinds of living organisms and they exhibit both autopoiesis and sense-making" (*ibid*., p. 25). This conceptualisation owes to the philosopher, Jakob von Uexküll (1864–1944), with whom originated the notion of the *Umwelt* as the 'bubble' in which the organism and the environment are connected through the organism's sensorimotor relationship with its surroundings – or, in other words, its meaningful world (Tyreman, 2018a).

That the autonomy and the sense-making emerge from the activity of the animate form within its environment is, for Thompson and Stapleton (2009), an argument that the orthodox cognitivist division between the internal mind and the external world should be abandoned. They claim, “Cognition is not an event happening inside the system; it is the relational process of sense-making that takes place between the system and its environment” (Thompson and Stapleton, p. 26). Of course, it is a controversial suggestion to anthropocentric, Kantian ways of thinking that non-human organisms can have either autonomy or the ability to make sense, but enactivist thought challenges this orthodoxy (Sheets-Johnstone, 2011, 2015; Cowley, 2018; de Jesus, 2018). De Jesus (2018) advances the ‘embodied mind’ thesis of Varela *et al.* (1991) and Thompson and Stapleton (2009, p. 861), expounding a biosemiotic-enactivist perspective, claiming that “all organisms ‘bring forth’ their own unique ‘worlds’ through processes of sense-making”, and, moreover, that the traditional division between the subject and object should be abandoned, to be replaced by an ontological coupling of the knower and the known, which are both co-defined by each other.

The enactivist turn in the science of consciousness, as can be surmised from the argument of de Jesus (2018) outlined above, has implications for the way we can think about social cognition, shared sense-making, and – in a phenomenological sense – co-inhabiting a meaningful world. I consider the implications of this for the current study further ahead in this chapter, after introducing the influential ideas of Fuchs and de Jaegher (2009), who take an enactivist approach to intersubjective sense-making (i.e. one that departs from representationalist and ‘theory of mind’ cognitivist assumptions), claiming that social

understanding, which they frame as 'participatory sense-making', "*arises in the moment-to-moment interaction of two subjects*" (Fuchs and de Jaegher, 2009, p. 466 [authors' emphasis]). The interaction, they claim, is characterised by what they call, "bodily resonance, affect attunement, coordination of gestures, facial and vocal expression" amongst other features (Fuchs and de Jaegher, 2009, p. 466). The four pillars of their argument are, in summary, that 1) social understanding arises from interaction, 2) intersubjectivity is dynamical and embodied, 3) intentions are expressed in action and can be perceptible to others, 4) intentions can be generated and transformed in the process of interacting.

The argument of Fuchs and de Jaegher (2009) is founded largely on the sensory modalities of vision and hearing – in the sense that bodily gestures, movements, speech and non-verbal vocalisations are visible and audible by those interacting. It is of note that they also reference touch, but only in passing (Fuchs and de Jaegher, 2009, p. 472, p. 473, p. 477); yet even without examining the haptic realm of interaction, they propose a model of enactive intersubjectivity influenced by Merleau-Ponty's theory of body incorporation, to portray the sense-making dyad as a coupling in which each individual attunes to the other. Merleau-Ponty proposed a 'unidirectional incorporation', according to Fuchs and de Jaegher (2009, p. 472), who quote the philosopher's example of the blind man extending his reach with a cane, which is effectively integrated into his body schema as a limb extension. Fuchs and de Jaegher develop this idea of incorporation so that – in intersubjective exchanges – it becomes a 'mutual incorporation'. Their illustrations are vivid – the tension and anticipation one feels whilst watching an acrobat, the mutual magnetism of the two athletes playing

tennis, the way that one's gaze acts like a limb, reaching towards the seen other – yet there is an oculo-audiocentrism at play in this account that side-steps the modality of tactile interaction, even when the authors further illustrate their model of participatory sense-making by referring to the structure of mother-infant dialogue. The model of mutual incorporation has relevance for the intersubjective dealings of cranial osteopaths and their patients and is referred to in the Findings and Discussion chapters.

Gallagher and Bower (2014, pp. 232-233) review the various trends they identify as converging within enactivism – the early phenomenological and Buddhist tradition, the middle cognitive science tradition and the late analytical philosophy of mind tradition, concluding that all three have their deficits in failing to emphasise the importance of embodiment as the ground of all cognition. They identify that the lived body, making sense in the world, should be considered to involve "the full ensemble of bodily factors that govern conscious life, but that operate in a pre-noetic fashion, below the level of conscious monitoring and manipulation" (*ibid*., p. 234). These factors include affectivity – emotion and feeling states, and somaesthetic factors such as hunger and fatigue. Gallagher and Bower (2014) reprise the intersubjectivity thesis of Fuchs and de Jaegher (2009) reviewed above, and, interestingly, perpetuate the side-step of the sensory modality of touch (again, even when discussing parent-child pedagogic interactions). They broaden the participatory intersubjectivity model to take into account the cultural contexts (involving gender, race, occupation, etc). in which embodied people communicate. They conclude with the observation – reminiscent of Straus' nativist concept of the human blueprint, or *Bauplan*

(Gallagher, 2017) – that human cognition would have a different structure if our bodies had a different form, i.e., if we were not erect bipeds, or lacked eyes or hands.

What is notably deficient in the account of Gallagher and Bower (2014) is the personhood and context of those whose lived bodies are described above – and this is perhaps not surprising, since the author's argument is a theoretical one. Larkin, Eatough and Osborn (2011) stake a claim for qualitative research methods, such as Interpretative Phenomenological Analysis, in contributing to the conversation about enactive, embodied experience, and particularly in demonstrating its situatedness in the worlds of meaning, relationships and objects of individuals who provide their own first-person account of their lived experience. As yet, there has been no significant uptake of this invitation.

2.3.3. Subjective aesthetic experience of meaning

It is one thing to speak of sense-making as a means of negotiating the meaningful world in our upright bodies, with our forward-facing eyes and our grasping hands (Lakoff and Johnson, 1980; Gallagher, 2017) and it is another to consider how it comes to be that individuals experience meaning (in their prenoetic, pre-reflective habitation of their Lifeworld). I do not intend to divert into an overview of the theories of meaning-generation – psychological, philosophical, anthropological, cultural, linguistic, or otherwise – but, instead, to consider the basic structure of the lived experience of meaning. The proposed structure of the lived experience of meaning is a theoretical construct that sits well with the enactivist account of cognition, and I go on to make reference to it in the Findings and Discussion chapter of this thesis. It owes to several strands of neuroscience, philosophy and

psychology – including the neuroscience of affectivity (Damasio, 1999; Panksepp, 2004), Polanyi's theories of tacit knowledge (1961, 1962, 1966), Gendlin's 1962 treatise, "Experience and the creation of meaning", as well as recent research into multisensory perception. It is to Gendlin's treatise that I now turn.

The theoretical accounts of enactive sense-making outlined above have had an influence on the field of applied psychological and human science research and practice, converging, as they seem to have done, with trends of understanding the body in the post-post-modern world that have their own genealogy in the works not only of Merleau-Ponty but also those of psychologist and philosopher – and colleague of Carl Rogers – Eugene Gendlin (1926-2017). I now outline briefly his intricate and originary work on the creation and experience of meaning (1962), that (i.e. meaning) he proposes to be embodied and preconceptual in origin. I then consider the argument, proposed by later thinkers (Lakoff and Johnson, 1980a, 1980b; Greenspan and Shanker, 2004; Sheets-Johnstone, 2011; Gallagher, 2017), that develops the anti-cognitivist theory that meaning not only arises in the body, but also that it represents something about the world.

In developing his ideas of embodied language, Gendlin claimed to be following in the footsteps of Dilthey, Husserl, Sartre and Merleau-Ponty, but also the pragmatist American philosophers, Peirce and Dewey, and diverging from post-modern, structuralists concepts of language. Gendlin's central thesis was that meaning is *felt* as it is *experienced*, and this experiential meaning contributes to conceptual cognition. He acknowledges that – unlike traditional theorists of language and cognition – he begins with the feeling in the body,

rather than the mentalised concept. He developed the ideas of embodied comprehension and embodied metaphor and suggests that they do not carry 'content' in themselves, yet go on to achieve symbolic utterance through verbalisation. Gendlin is optimistic that language can be found that gives expression to experienced feeling:

> "There is no necessity that language kill experiencing. We shall devise a method so that language can help us to refer to our experiencing, help us create and specify aspects of it, help us convey these sharply or roughly. We can use any word in an experiential sense. We need not limit ourselves only to the word's logical and objective definition"
>
> Gendlin (1962), p. 19.

He defines experiencing as "*concrete*" (*ibid*. p. 27 [author's emphasis]), provisional, intricate and "*supralogical*" (*ibid*. p. 29 [author's emphasis]), and awaiting conceptualisation – although, he claims, it is not the case that felt meaning is merely an analogue of the cognitive concept, but it has its own psychological functions.

Gendlin (1962) describes the process whereby an embodied metaphor arises: it entails the transfer of meaning from an old situation to a new situation, via the attribution of a new symbol (e.g. a word, or a scenario) to the felt meaning that is only partially symbolised. His reasoning is dense, and not always easy to follow, but he gives an example of how understanding emerges from the metaphorical transfer of the symbol for the old felt meaning to the new situation by giving the process a clinical context, explaining how the

therapist can help the client make this metaphorical shift. It is this concept of Gendlin's, in particular, that has relevance for the present study, as will be illustrated in the Discussion chapter.

Gendlin's theory hints at the possibility, without fully explicating it, that the meaning we experience at a felt, embodied level, is capable of having content, i.e. that it is capable of representing something in the world. Gendlin, being a phenomenological psychotherapist, is particularly invested in the idea that this sort of 'something in the world' is a previously experienced or presently anticipated event within the meaningful world of the client. This notion features in the current discourse about enactivism and embodied consciousness, with reference to Gendlin and also with reference to Lakoff and Johnson's theories about the structure and purpose of metaphors and their embodied origins, summarised within the quotation below:

> "[M]etaphor is not merely a matter of language. It is a matter of conceptual structure. A conceptual structure is not merely a matter of the intellect – it involves all the natural dimensions of our experience, including aspects of our sense experiences: color, shape, texture, sound, etc."
>
> Lakoff and Johnson (1980), p. 235.

Finlay (2015) is an example of a practitioner-researcher who uses the theories and methods of both Gendlin and Lakoff and Johnson in considering how embodied metaphor emerges as a vehicle for sense-making for both client and therapist within the practice of

psychotherapy. I consider the relevance of Finlay (2015) below, within the current chapter, and also in the Discussion chapter.

The idea that we can have a pre-reflective understanding of concepts that represent something in the world (i.e. prenoetic understanding that may or may not arise to verbalisable consciousness) is controversial. A more orthodox cognitivist definition of representation is an internal, mental, symbol that stands for an object in the real world, or an abstract proposition that can be communicated via symbols (such as words or metaphors) (Hutto and Myin, 2012); Gallagher (2017), however, surveys the evolution of thinking about representationalism, and suggests that artificial intelligence research has brought to light deficits within the cognitivist model of representationalism. He argues for a return to a phenomenological framework for understanding cognition, reprising the anti-representationalist perspective of Dreyfus (2002), who claims that the practical acquisition of skills argues for a more action-orientated definition of embodied knowing. This, in essence, is an argument for Heidegger's ontological proposition of the mode of *Zuhanden*, in which there is no discontinuity between the function, the tool, the practical hand and the person using it purposely (Mulhall, 2005, pp. 42-43).

This line of anti-representationalist reasoning tends towards the idea that the embodied experience of meaning does, in fact, entail conceptual understanding – conceptual understanding that has affective, aesthetic and motoric qualities to it (whether or not they have symbols attached to them), whilst they are in the realm of the prenoetic. Sheets-

Johnstone (2011, 2017) is one philosopher who discusses and argues for this proposition. She claims,

> "Our bodies are indeed semantic templates. Hence it is not surprising that fundamental human concepts are corporeal concepts."
>
> Sheets-Johnstone (2017), p. 10.

She cites Husserl's example of the 'I move' and the 'I do' preceding the 'I can move' and the 'I can do' (Husserl, 1989, p. 273; cited *ibid*, p. 116), provides the example of a being engaged in the tactile-kinesthetic act of chewing, or, as she puts it, "*grinding something to pieces*" (*ibid*, p. 116 [author's emphasis]) and claims that in such an act, "corporeal powers give rise to corporeal concepts, fundamental human concepts such as grinding, sharpness, hardness, and so on" (*ibid*, p. 116). Noland (2010) and Reynolds (2007) are two other authors researching the philosophy and cultural practice of dance who agree with Sheets-Johnstone that the body 'has' concepts – and perhaps it is because these three scholars have a background or research interest in dance that they consider imagination to be embodied in origin, whereas Gendlin (1962), being a psychotherapist, was unable to make this final leap. The idea of the corporeality of concepts is something I return to in the Discussion chapter.

I now wish to make a very brief reference to a recent paradigm shift that is unfolding in the neuroscientific understanding of sensory perception – from modular (i.e. considering each sensory mode as a separate and parallel system) to multisensory (i.e. considering the interaction of sensory functions, as described by Bruno and Pavani (2018)). The

multisensory model helps to make sense of some of the enactivist concepts introduced above (such as 'mutual incorporation'), and helps to inform some aspects of my discussion of the findings of the study, later in the thesis.

The classical Aristotelian view of the senses has been shown to be an allegory, and, although traditional reference books still organise the senses into modular chapters, typically beginning with vision, moving onto audition, then to the vestibular system, and following that addressing touch, olfaction and gustation (Goldstein and Brockmole, 2017; Wolfe *et al.* 2018), there has been a departure from the empiricist psychophysical model that frames perception as the *passive* product of sense-organ stimulation by objects in the real world. Bruno and Pavani (2018), citing the work of Gibson (1962, 1966, 1979), Jeannerod (2006) and Noë (2004), reframe sensory perception as *active* exploration of the world. They sub-divide their book into chapters based on the functions of body-perception, perception for action, object perception and recognition, and the perception of food; they also investigate human sensory experience of space and time. Each of the traditional sensory modalities are investigated as part of functional, dynamical systems, and not given their own mode-specific chapter.

It is claimed that cranial osteopathy involves "a highly developed sense of touch to feel subtle changes of tension and tissue quality in the living anatomy of the whole body [of the patient]" (SCCO, no date) and to evoke sensations of relaxation, release, unwinding, warmth, softening and balancing in patients who receive the treatment (Mulcahy and Vaughan, 2014). It has been suggested that such therapeutic embodied experiences might

be the product of interoceptive functions (Payne, Levine and Crane-Godreau, 2015). This is an emerging field of psychological neuroscience (Bruno and Pavani, 2018), and there is as yet no taxonomic consensus that helps us to categorise human perceptive functions in a definitive way. For this reason, I illustrate below in Table 1 a selection of sensory functions (some of which have been identified in the late twentieth century) that may have relevance for our understanding of the experience of giving and receiving cranial osteopathic treatment, according to the findings of the current study.

TABLE 1 PERCEPTUAL FUNCTIONS[8]

Perceptual Function	Description and source
Perception of light touch	Ability to detect light, static cutaneous contact.
Perception of painful stimulus (nociception)	Painful sensations, as mechanical, thermal or chemical stimuli are applied to mechano-, thermo- and chemo-receptors within tissues.
Perception of itch	An itching sensation, induced by pruritic stimulus to the skin, giving a perception of itch.
Perception of affective touch	A hedonic sensation, induced by gentle stroking of the skin.
Proprioception, kinaesthesia and vibration sense	A form of own-body somatosensation, necessary for controlling our body in space, for balance and for co-ordination. Mechanoreceptors within joints and muscles record changes in posture and muscle tone. Kinaesthesia refers specifically to the sensation of joints moving. Vibration is detected through a special class of mechanoreceptors (Stillman, 2002).
Visceral interoception	Signals perceived as arising from the activity of the internal organs, such as vasomotor activity, hunger and thirst (Craig, 2002).
Mechanical interoception	Temperature, pain, affective touch sensations arising from within the body (and not just from external stimulus of the skin) which are believed to convey emotional qualities as well as autonomic homeostatic responses (Craig, 2002; Critchley and Garfinkel, 2017).
Vestibular sensation	The sense that conveys inputs arising from linear and angular motion of the head in space. It is also sensitive to the earth's gravitational pull and is therefore crucial for our sense of equilibrium; it also contributes to the distinction between one's own motion and the motion of other objects or people.
Sense of selfhood, agency and body-ownership	A sense of owning a body that is thought to be a basic form of self-consciousness and is proposed to have three components: full-body ownership, first-person perspective and self-location (Tsakiris *et al.*, 2007).
Sense of body-part ownership	The sense that a part of the body, such as a hand or an arm, belongs to oneself, which is related to a sense of one's body 'schema' and is in play in both 'phantom limb' experiences and the 'rubber hand illusion'.
Awareness of body boundary and peri-personal space	The sense of one's body having an outer perimeter, defined by skin, hair, nails and, in some definitions, clothes, shoes and hats; the peri-personal space is the sense of the proximal space around a person.
Body extension	The sense that the body has extended by virtue of wearing a hat or a rucksack, e.g. when negotiating doorways; or by using a pair of scissors, which relay the tactile sensations as though they were part of the hand itself (de Preester and Tsakiris, 2009).
Body incorporation	The sense that a prosthetic limb or a walking-stick has become a part of oneself, incorporated within one's body schema (*ibid*).

[8] Adapted from Bruno and Pavani (2018), with additional sources (cited within).

2.3.4. Literature on phenomenological, enactive and subjective aesthetic sense-making in clinical practice

In this section, I consider examples of recent literature that embeds the theoretical foundations of phenomenological, enactive, situated and subjective aesthetic sense-making outlined above in clinical practice, specifically within psychotherapy, physiotherapy, osteopathy and cranial osteopathy.

In a paper on embodied sense-making and the role of metaphor within relational-centred psychotherapy, briefly mentioned above, Finlay (2015, p. 342) provides case studies that give examples of the way she uses a Gendlinesque method of dwelling and experiencing embodied meaning, which comes to her as "ambivalent, sedimented meanings and texture", when she is "fully present" and with her client, "sensing, moving, empathizing, responding, and resonating" (*ibid*., p. 342). She writes about her multisensory engagement with her clients in which she uses the five archetypal modalities, but also "a form of sixth sense related to mind, including cognition, emotion, forethought, and intuition" (*ibid*., p. 342). Other psychotherapists similarly describe their embodied experiences during their practice (Shaw, 2003; Röhricht, Gallagher and Hutto, 2014; Allan, Eatough and Ungar, 2015). Totton (2018) has recently propounded a form of post-Reichian body psychotherapy that he calls "embodied relating", a contemporary theory of body psychotherapy informed by Merleau-Ponty, Gendlin and Varela, Thompson and Rosch. The concept of "embodied relating" revises Wilhelm Reich's coinage of "vegetative identification" (Boadella, 2014, p. 104) and may involve elements of therapeutic touch as well as movement. There are no published accounts of the experiences of patients or practitioners who undergo/practice

body psychotherapy, and it is therefore difficult to draw conclusions about its capacity to help explain the phenomenon analysed in the current study.

These embodied and body-psychotherapeutic practices are revisited in the Discussion chapter of the current thesis, particularly in the light of evident structural and processual similarities with the practice and experience of cranial osteopathy that have emerged during the conduct of this study.

A theoretical paper by Øberg *et al.* (2015) argues for the role of embodied-enactive clinical reasoning within physical therapy. The authors propose an expansion of the scope of clinical reasoning to include the embodied knowing that skilled practitioners develop in their assessment and treatment of physical therapy patients. They propose that physical therapists can be said to draw on their own senses of body schema, image, agency and ownership to make pre-reflective sense of their patients' presentations. They propose that this embodied insight can inform clinical reasoning in both pre-reflective and reflective ways. It is interesting that the proposed noemata accessible to this method of embodied-enactive clinical reasoning include "words, gestures, and bodily aspects that are pre-reflective for the patient but often perceptible for the PT [i.e. physical therapist] in such things as tone, posture, and habitual movements" (Øberg *et al.*, 2015, p. 248). Apart from a brief reference in the concluding paragraph, the authors do not, however, explore the role of touch as a pre-reflective mode of communication. This omission does not limit its relevance as a model for understanding embodied-enactive clinical reasoning within

physical therapies such as cranial osteopathy, but it does leave an interesting aspect of these practices unexplored.

Although osteopath researchers have recently been influenced by phenomenology, they have not yet begun to utilise the concept of embodied-enactive clinical reasoning. A qualitative study by Consedine, Standen and Niven (2016), which used a hermeneutic phenomenological research method to explore the lived experience of osteopathic touch, contributes to the understanding of the role and function of touch in the therapeutic context of osteopathic manual assessment and treatment, but fails to embed its findings within the context of enactivist theory, or even accounts of embodied cognition. The authors propose a dialogic role for touch as an instrument of communication and they call this form of dialogue, "knowing hands convers[ing] with an expressive body", emphasising what they refer to as the 'bi-directional' reciprocity of information exchange. These findings readily find accommodation within theories of intersubjective, embodied, participatory sense-making, and I return to them as a point of reference in the discussion of the findings of the current study.

The paper by Consedine, Standen and Niven (2016) arose from a study of the lived experience of osteopathic patients. The paper I consider next (Stuart, 2016) is – by contrast – a complex philosophical explication of 'enkinaesthetic theory', an elaboration of the phenomenological ideas of Merleau-Ponty and Gendlin in the sphere of pre-reflective, embodied, felt experiencing. Stuart assays an explication of the aesthetic structure of prenoetic 'Being-in-the-world', using embodied expressivity and its contribution to cranial

osteopathic clinical reasoning as an enkinaesthetic case-study. Stuart is interested in the aesthetic layers of prenoetic, pre-theoretical lived experience. Her rich account of human sense-making in a world of aesthetic and affective meaningfulness foregrounds the role of movement and motoric intentionality in a way that brings to mind Sheets-Johnstone's argument that – in discussions of worldly embodiedness – primacy be given to movement rather than the aesthetic component of the sensori-motor loop (Sheets-Johnstone, 2011). Stuart proposes the felt sense of movement, kinaesthesia, as the main instrument of embodied sense-making, although her philosophical paper has less focus on the neurophysiology of kinaesthesia and more on its ability to stand as a short-hand for the 'plenisentient' modalities we use to make sense of our world, its objects and other people. Stuart makes use of the concept of 'entanglement' to describe the activity we effect in the course of our meaningful 'Being-in-the-world'.

In order to illustrate the concept of 'enkinaesthetic entanglement', Stuart (2016, p. 27) examines the "intriguing" example of cranial osteopathic palpation, which she calls 'osteopathic manual listening' after encountering the work of Gens and Roche (2014) who describe osteopathic palpation in creative, expressive terms, "a singular experience: that of a sense or a *feeling* not only of the bodily life of the patient by the osteopath, but also of the relationship between their corporeities"[9] (Gens and Roche, 2014, p. 4). Stuart (2016) portrays this form of sensory engagement as a "synaesthetic listening-feeling process, the

[9] "Cette écoute ostéopathique est une expérience singulière: celle d'un sentir ou d'un *feeling* non seulement de la vie corporelle du patient de l'ostéopathe, mais de la relation entre la corporéité du patient et celle de son Thérapeute".

gentle touch – and even non-touch – of palpation listening for rhythms and arhythms", characterised by non-striving receptivity and "an openness to what presents itself" (*ibid*., p. 27). Referencing Merleau-Ponty, she claims that this manner of cranial osteopathic intersubjectivity is "first and foremost an enkinaesthetic intertwining, a circle of the touched and the touching and what comes to light, that is, what is brought forth through the feeling shifting somatic sense" (*ibid*., p. 27).

In this paper, Stuart (2016) presents a challenge to cranial osteopathy, and those who research it, to provide some insight into that which – from the perspective of the lay observer – seems 'intriguing', inexplicable or implausible. The present study engages with this very challenge, and I return to this paper in the Discussion chapter, to consider the findings in the light of its insight.

2.4. Hermeneutic Model of Medicine and Healthcare

Throughout this review of the literature and theory, I have made reference to phenomenological accounts of intersubjectivity (see discussion of Fuchs and de Jaegher (2009) and Stuart (2016) above). I now explore intersubjectivity as a structural feature of medical praxis that is hermeneutic, i.e. that involves the interpretation of a patient's signs, symptoms and story by a skilled physician-hermeneut. This Gadamerian hermeneutic model of medicine owes to the work of Svenaeus (2000a, 2000b, 2003), and represents a defence of the one-to-one therapeutic relationship at a time when western medicine is adopting technological and artificial intelligence solutions to deliver both demographic based prophylactic medicine (*viz*. the debate about the systemic, preventative prescription of

statins: Collins *et al.*, 2016; Godlee, 2016) and individualised 'precision' medicine based on targeted pharmaceuticals and genomics (Mesko, 2017).

2.4.1. Horizontverschmelzung

Svenaeus (2000a, 2000b) advances the idea that the hermeneutic method may be applied to the dialogue between the patient and the doctor, in a way that shares structural similarities with textual hermeneusis. In this model, the clinical hermeneut comes to understand the lived experience of the patient by participating in a dialogue that produces a rich and dynamic account of the patient's story, but also involves an element of shared understanding – a therapeutic intersubjectivity. The metaphor that Svenaeus uses for this shared understanding is the Gadamerian concept of the 'fusion of horizons of meaning' (the *Horizontverschmelzung*).[10] This merging of horizons does not require the doctor and the patient to share the same interpretation, as their viewing-points and perspectives remain particular and distinct; yet, despite the asymmetry in the relationship between the doctor and the patient, there is meeting of minds that involves an intersubjective sharing. Svenaeus (2000a) expresses it in this way:

> "The doctor must understand the patient as an understanding person, through projecting himself into the patient's understanding and vice versa; and what the doctor and patient say to each other must make sense for both parties. The discourse of the meeting must indeed take place through

[10] Gadamer (1989, p. 305), proposes the structure of the hermeneutic fusion of horizons.

> a shared understanding in the sense that both parties understand what the other is saying. Language, as the medium of the meeting, must then have a mutual attunement that makes it into a dialogue"
>
> Svenaeus (2000a), p. 147.

For Svenaeus, this dialogue is one that takes a verbalised form. I propose that the description of cranial osteopathy by O'Brien (2013, p. 112), described above, which entails "a subtle, variable form of communication between two persons" and involving the transference of tranquillity from osteopath to patient, might find accommodation with this hermeneutic model. The cranial osteopathic encounter, however, does not foreground the use of verbalised discourse, but instead uses tactile communication. Svenaeus (2000a, 2000b) does not consider the role of touch as a vehicle for the intersubjective haptic hermeneusis that may be said to occur within the cranial osteopathic dynamic – and within other physical, manual or complementary therapies. As I have indicated in passing throughout this review of literature and theory, there is often insufficient account taken of the role of touch even within the phenomenological, enactive and therapeutic studies that explore our situated participation in our meaningful world (see discussion of Fuchs and de Jaegher (2009), Gallagher and Bower (2014), Øberg, Normann and Gallagher (2015)). In the following section, I consider some examples of recent literature that addresses this deficit, exploring the role of social, affective and therapeutic touch, which provides a foundation for understanding some of the themes arising from the current study, and which are set out in the Findings and Discussion chapters of this thesis.

2.5. Therapeutic Touch

Therapeutic touch is a complex phenomenon that is open to several readings (Kelly *et al.*, 2017). Therapeutic touch may be 'technical', in the sense that it is used to alter bodily states, e.g. in the case of massage. The phenomenologist and pedagogue, Max van Manen (1999), describes two other categories of therapeutic touch – the 'gnostic' (i.e. assessing, diagnostic mode) and the 'pathic' (i.e. the nurturing mode). In a phenomenological study of CAM patients in England, Sointu (2013) concludes that patients associate the diagnostic mode of biomedical touch with distancing and disembodying, and the nurturing mode of therapeutic touch with comforting and healing. Some osteopaths and physiotherapists argue for the use of therapeutic touch as a way of generating meaningful communication (Nathan, 1999; Consedine, Standen and Niven, 2016; Moffatt and Kerry, 2018), yet there is the counter-argument that touch can be a source of miscommunication and misconstrual, with erotic overtones (Moffatt and Kerry, 2018) and cultural misunderstandings, and therefore a risk to both patient and practitioner alike (Kelly *et al.*, 2017).

An enactivist account of intersubjective therapeutic intercorporeity, such as the enkinaesthetic model propounded by Stuart (2016), analysed above, suggests that therapeutic touch bears a more nuanced reading, revealing its capacity for multi-layered, plenisentient and empathic exchange. It can be framed by the Husserlian metaphor of *Paarung*, in which there is a 'pairing' between self and other (de Preester, 2008). This intersubjective, intercorporeal apposition enables a transfer of aesthetic experience, a mutually constitutive body-map schema operating in the haptic domain (Serino and Haggard, 2010). It is creative, revelatory and mutually enfolding, or from a Merleau-Pontian

perspective, ‘intentionally transgressive’ (de Preester, 2008, p. 133). Merleau-Ponty famously conceived of the ‘chiasm’ as a device to depict the reversibility of toucher and touched through touching. He writes,

> “There is a circle of the touched and the touching, the touched takes hold of the touching; there is a circle of the visible and the seeing, the seeing is not without visible existence; there is even an inscription of the touching in the visible, of the seeing in the tangible— and the converse; there is finally a propagation of these exchanges to all the bodies of the same type and of the same style which I see and touch— and this by virtue of the fundamental fission or segregation of the sentient and the sensible which, laterally, makes the organs of my body communicate and founds transitivity from one body to another.”
>
> Merleau-Ponty (1968), p. 143.

This mutual transitivity of touch between the senser (the knower) and the sensed (the known) is a model with relevance to the lived experience of therapeutic touch in the current study and will be discussed with reference to the findings of the current study later on in the thesis. I now turn to some recent advances in the neurophysiological understanding of affective, social and therapeutic touch.

2.5.1. Affective touch

Vallbo, Löken and Wessberg (2016, p. 1) describe the late twentieth-century microneurographic techniques that revealed the presence of the neural pathways that communicate what they call 'sensual touch' (and which McGlone *et al.* (2007) call 'emotional touch', and Ackerley, Backlund Wasling and McGlone (2016) call 'affective touch') – as distinct from light touch, pressure and nociception – via C tactile (CT) afferents. The CT system has been studied and defined as having a "key role in physical contact with an amiable conspecific, that is, your parents, lover, kin or friends" (p. 1). It is stimulated by light, stroking touch, particularly to non-glabrous skin (i.e. where there are hair follicles) (Rolls, 2016). The CT system is considered to play a role in 'social touch', which is hypothesised to support primate and human interaction and bonding (Gallace and Spence, 2016; Morrison, 2016).

Some studies in the field of social touch have identified that affective touch seems to have the effect of reducing cortisol levels and lowering the heart rate in the face of a stressful stimulus, although these studies were undertaken using intimate partners (Ditzen *et al.*, 2007). It is thought that affective touch, whether of a sexual or non-sexual nature, promotes the expression of oxytocin, a hormone that promotes social and affective bonding (Gallace and Spence, 2010). Nummenmaa *et al.* (2016) show that social touch also has the effect of modulating μ-opioid receptor activity, suggesting that it operates in the manner of other rewarding stimuli, such as food and opiate drugs.

McGlone, Walker and Ackerley (2016) suggest that social touch might have evolved in all animal species alongside grooming behaviours for functional reasons (such as hygiene and aesthetic advantage), and speculate that there might be ulterior – or at least parallel – drivers, including the loosely-defined notion that social touch "actually makes us *feel* good as well" (McGlone, Walker and Ackerley, 2016, p. 265). The applied context of the above paper is the personal care industry, and not medicine or healthcare. It might be possible to envisage a transfer of these ethological arguments to a healthcare context where touch is utilised, but there is a difficulty in that CT fibres, and their related oxytocinergic and opioidergic actions, have been demonstrated to conduct signals stimulated by slow, caressing brushing or stroking action – and not the relatively still, continuous touch utilised in cranial osteopathic 'manual listening'.

2.5.2. Touch in cranial osteopathy

There is a recent study, however, that has the potential to shed light on the phenomenon of cranial osteopathic touch, as reported by Cerritelli *et al.* (2017). The study examined the effect on brain functional connectivity (as measured by functional MRI (fMRI) scan) of different attentional states of an operator who applied static, or continuous, bilateral, skin-to-skin touch to the lateral malleoli (the external part of the ankle) of forty healthy male participants. They were randomised into two groups: with the first, the operator paid explicit attention to the tactile perception he could discern from his hands; with the second, the operator was distracted by an auditory stimulus. The pressure applied was 0.2 N, based on established evidence that CT fibres are stimulated within the range of 0.2 to 0.4 N. The

operator was trained to achieve this precise pressure force, and was able to reproduce it reliably without visual feedback, as measured by force transducers.

With the first group, the operator was asked to maintain his attention on his perception of the "consistency, density, temperature, responsiveness and motility (e.g., myofascial movements)" of each participant's "tissue" (Cerritelli *et al.*, 2017, p. 3). It is not specified whether the attention was directed towards the contact points, specific classes of tissues, the whole body of the participant, or their whole being. With the second group, the operator listened to random bleeps, delivered through headphones. For both groups, the operator maintained the same position, points of contact and – it is said – level of attention (or inattention) for five fMRI runs lasting 5.5 minutes each.

The study appears to have been conducted with exemplary attention to factors that could have influenced randomisation, blinding, and measurement validity and reliability, and the research methods are reported with precision to permit the trial to be repeated (Cerritelli *et al.*, 2017, pp. 2-4). The reported results suggest that prolonged static touch applied by an operator "engaged with focused tactile attention" produced statistically significant differences in functional brain connectivity in participants (compared to participants whose operator was distracted by auditory stimuli), but these effects were recorded only after 15 minutes of continuous touch.

The authors conclude that, given that the neural networks detected as active during the fMRI scans – the insula and the posterior cingulate gyrus – are believed to be responsive to interoceptive stimuli, the experiment points towards a specific interoceptive role for

prolonged attentive touch. They postulate that prolonged, attentive, static touch may play a part in the therapeutic effects of manual therapies that involve this type of touch. I consider the implications of this proposition in further depth in the Discussion chapter, below.

2.6. Chapter Conclusion

The current study aims to contribute to the body of literature exploring the phenomenon of complementary and alternative therapies – and in particular cranial osteopathy – as they are experienced by their patients and practitioners. As the preceding review of literature and theory has demonstrated, there have been very few investigations into this rich field (Lee-Treweek (2002), Mulcahy and Vaughan (2014), Stuart (2016) are exceptions), yet there are several potential theoretical spheres that could accommodate the complex and multi-faceted phenomenon of cranial osteopathy, and the sense-making of cranial osteopaths and their patients. As I hope to have demonstrated, these include:

- The phenomenological tradition of experiencing embodied meaning.
- The enactivist paradigm that views consciousness as the function of reaching out into the world, and intersubjective interactions as reciprocal aesthetic incorporation.
- The idea that medicine is a genre of cultural practice, with its own semiology of meaning-performance and production.
- The model of medicine as a shared, hermeneutic endeavour.
- The multisensory model of perception and the neuroscience of the experience of touch.

CHAPTER 3: METHODOLOGY

3.1. Chapter Introduction

This chapter surveys the methodological choices facing the researcher and the eventual decisions made in order to plan and conduct the research project, so as to address the question, 'What sense do osteopaths and their patients make of the phenomenon of cranial osteopathy?'

In this chapter, I explore the philosophical and praxial context of the research problem (which is described in the Introduction chapter), and explain the ontological stance of hermeneutic realism that underpins the study. I then consider the theoretical perspective that accords with hermeneutic realism and the methodological premises that inform the research design. I justify the methodological choices I have made and explain the steps I have taken to maintain academic and professional rigour. I also explain the role played in the conduct of the study by researcher reflexivity.

3.2. Philosophical and Praxial Context of the Research Problem

The research problem articulated in the Introduction chapter required a philosophical framework that permitted an exploration of what it is like to undergo subtle aesthetic (i.e. sensory) experiences in a healthcare context, the mechanisms of physical therapies that involve close contact and the therapeutic use of touch, and the simultaneous experience of seemingly salutogenic phenomena by patients and their practitioners. Although it should have been possible to look beyond the corpus of western philosophy for such a framework, I, as an osteopath, am professionally required by the regulator of osteopathy in the UK, the

General Osteopathic Council (GOsC), to operate as an evidence-based practitioner (General Osteopathic Council, 2019a). I had therefore found myself somewhat entrained within the discipline of the philosophy of medicine and healthcare as it is taught and studied in western academia;[11] and I did not initially look beyond its scope for ways of understanding ontology and epistemology, the touch-stones of philosophical orientation.

3.2.1. Paradigm of Evidence-Based Medicine (EBM)

As it is difficult for the researcher – born into a twentieth-century Britain with its particular geo-political, socio-economic and cultural contexts – to see the world from a non-western standpoint (Baggini, 2018), so it is difficult to consider an ontology and related epistemology that does not place human empiricist reason at its centre, supervenient in a world of commodifiable *res extensa* (Treanor, 2015). The objectivist, dualist ontological perspective, that in the post-Cartesian, post-Newtonian age provided a stable ground for the scientific revolutions of the Enlightenment, has carried over to inform the paradigm underpinning so-called orthodox western medicine, including the late twentieth-century 'brand' of Evidence-Based Medicine (EBM) (Loughlin, 2009a). According to the conventions of objectivism, the therapeutic phenomenon of cranial osteopathy can be thought to have no plausible mechanistic basis (Ferré and Barbin, 1991; Hartman, 2005, 2006a; Gabutti and Draper Rodi, 2014; McGrath, 2015). It defies objectivist ontological presuppositions to suggest that cranial osteopathic interventions, which involve the lightest of physical touch – and

[11] See Baggini (2018) on academic philosophy's historical occidentocentrism.

sometimes no touch at all – may create a profound, combined, mental-physical transformation in the health of its recipients, and yet, in my experience as an osteopath – and, as explained in the Literature review chapter – this seems to be the case.

In recent years, philosophers, historians, sociologists, anthropologists, cultural theorists and doctors have challenged the EBM discourse as philosophically confused (Loughlin, 2009), ahistorically scientistic (Loughlin, Lewith and Falkenberg, 2013), culturally hegemonic (Jones, 2004; Lupton, 2012), unmoored from socio-economic contexts (Levin and Browner, 2005), micro-fascist in the manner of its enforcement (Holmes *et al.* 2006) and responsible for perpetuating a deficit in clinical judgement in the practice of medicine (Spence, 2014; van Baalen and Boon, 2015). Loughlin (2009) makes a case for the faulty genealogy of EBM, locating its 'parentage' in logical positivism, with its objectivist ontological stance. The philosopher, Charles Taylor, finds a void at the heart of the EBM, a discourse which "automatically removes from consideration any of the therapies which deal with human beings as self-interpreting human beings, where we listen to the person, help the person see what's going on" (Taylor, Carnevale and Weinstock, 2011, p. 437).

More recently, however, the principles and practice of EBM have been re-examined (Kerry *et al.*, 2012; Greenhalgh, Howick and Maskrey, 2014; Greenhalgh *et al.*, 2015; Kelly *et al.*, 2015), with the aim of ensuring that the experience and values of patients are not neglected in the formation of evidence-based guidelines. Some osteopaths in the UK seem to have embraced – or at least accepted – the evidence-based approach to practice (Humpage, 2011; Weber and Rajendran, 2018; Inman and Thomson, 2019). There is less evidence that

osteopaths who practice cranial osteopathy have yet found a way to navigate the epistemological challenges set by EBM (Zegarra-Parodi and Cerritelli, 2016).

3.2.2. Praxial genesis of the research problem

The research problem outlined in the context of the philosophical issues described above – i.e. explaining the mechanism of cranial osteopathy as a property that emerges from the interpersonal osteopath-patient relationship – can be considered to concern the understanding, experience, sense-making and meaning-making that cranial osteopaths and their patients engage in, as self-interpreting human beings, in a specific cultural context. Framed in this way, explorations of the mechanism and meaning of cranial osteopathy may be accommodated more properly by the disciplines of social, human and health research than by the objectivist, positivist and empiricist assumptions of EBM. The present study does not aim to examine the *physiology* or the *efficacy* of cranial osteopathic interventions. Had it done so, an ontological and epistemological perspective consistent with the stance of EBM would necessarily have required accommodation; but since the research problem arose in "the swampy lowland" of practice (Schön, 1983, p. 42) – in my struggle to find ways to explain my cranial osteopathic practice to patients – an alternative proposition was required.

3.2.3. Alternative paradigms

Alternatives to the dualist, objectivist, positivist ontology and epistemology of EBM can be broadly categorised as pragmatist, subjectivist, constructivist and interpretative. There would have been value in addressing the research problem from any of these platforms. A

mixed-methods investigation into the experiences and patient-reported outcomes of cranial osteopathic treatments would have contributed to a pragmatic understanding of how cranial osteopathy seems to work. A Foucauldian discourse analysis of the accounts of cranial osteopathic practitioners and patients could have generated a post-modern reading of the structure of complementary therapy as defiance against (or even as a replication of) the grip of orthodox medicine. It would have been possible to take a constructivist approach, using grounded theory or ethnographic methods to make sense of the theory-construction of cranial osteopaths and their participants, from an etic perspective. Each of these approaches would have had value, but none of them would have been able to provide an answer that would reach into the praxial realm of the problem, in which I, the researcher, was situated, and wherefrom I could not be abstracted during the conduct of the study.

A further paradigm was therefore explored, that of interpretivism, which was hoped to be able to accommodate the reflexive, insider-perspective (Finefter-Rosenbluh, 2017) of the researcher, and which is explored further below. The tradition of phenomenology is the most commonly used interpretive qualitative health research method, according to Green and Thorogood (2018).

3.2.4. Phenomenology as interpretative research method

I gave a brief introduction to the philosophical tradition and method of phenomenology in the Introduction, and wish to focus now on a particular interpretation of Heidegger's ontological project, that provided by renowned Heidegger scholar, Thomas Sheehan.

Sheehan (2015) claims to have generated a paradigm shift in understanding Heidegger, at the core of which is the understanding that, for Heidegger, all human engagement with 'the things themselves' (i.e. phenomena) occurs anew in the instance of engagement, and that 'being' is synonymous with 'meaning' (Sheehan, 2014, p. 260); this means not only that humans and the phenomena they encounter co-constitute meaningful Being-in-the-world, but also that there is no existence without there being meaning.

Since the research problem concerns the understanding, experience and explanation of the subtle and aesthetic phenomena that arise in a cranial osteopathic treatment, it is proposed that a phenomenological framework provides a suitable context to explore sense-making about cranial osteopathy – particularly when what is at issue is the ontological question at the heart of the therapeutic transaction (Tyreman, 2018b). I provide further insight into the proposition of Sheehan (2014, 2015) – and its relevance for the current study – in the next section.

3.2.5. Ontology and epistemology of hermeneutic realism

Phenomenology as a philosophy – and as a hermeneutic research method (i.e. a research method appropriate for the field of the human sciences in which explanations can be argued to be a matter of interpretation) – was propagated by philosophers who followed in the tradition of Husserl and Heidegger, such as Bernstein (1985), Dreyfus (1980, 1991) and Gadamer (1989), who envisaged hermeneutically-mediated plural and relational realms of realism. This tradition has recently been articulated as a basis for understanding matters of human inquiry, through qualitative social and human science research, by Yanchar (2015).

Yanchar (2015) proposes hermeneutic realism as an ontological proposition that is fitting for qualitative inquiry,

> "by virtue of its unique human way of accounting for human experience and due to its implications for investigations into the complicated, yet richly meaningful, world of human activity"
>
> Yanchar (2015), p. 108.

Hermeneutic realism, Yanchar (2015) goes on to say, encompasses multiple manifestations of the phenomena of the world, without abandoning the concept of truth entirely: what is true about the things of the world is not to be found in their substance or essence, but in the particular 'participation' we take in them.

This ontology and epistemology, with their roots in Heidegger's onto-epistemic concept of *Dasein*, are based on the 'concernful involvement' we have as humans in our meaningful world (Yanchar, 2015). Events matter to us; we are situated in the world; we are "engaged, fully embodied agents, inevitably enmeshed in meaningful contexts of historical-cultural practices" (Yanchar, 2015, p. 109). Another way of putting this is to say that the phenomena we encounter as we are engaged in the world express, or disclose, themselves as *Zuhanden*, or 'ready-to-hand',[12] to use another Heideggerian conception. The world discloses itself by

[12] An ontological construct of Heidegger's, suggesting the mode in which we make use of 'gear' or 'stuff' in our world that is ready-to-hand, such as the hammer we seize and use without analysing or second-guessing it (Mulhall, 2005, p. 47).

virtue of the 'ready-to-hand' meaning we make of it (Polanyi, 1961, 1962, 1966; Giddens, 1976; Taylor 1985 and 1995; Marion, 1999, 2012; Mol, 2002; Sheehan, 2014; Dreyfus and Taylor, 2015). Another way of expressing this idea is to consider Heidegger's use of the ancient Greek concept of *Aletheia* ('unconcealment'), which he uses to frame the manner of disclosure of the world. According to Bartky (2009, pp. 215-216), *Aletheia* "means the unconcealment of that which is, the stepping into the open of that which was heretofore veiled or obscured. When a world happens, that-which-is comes out of concealment." Sheehan (2014, p. 22) goes as far as to say that Heidegger's chief concern in *Being and Time* was the identification of the openness that allows the unconcealment of the phenomenologically meaningful world; the term most commonly associated with this quality of openness is *Lichtung* ('clearing'). I have introduced the ontological concepts of 'world-disclosure', 'ready-to-hand', 'unconcealment' and 'clearing' at this stage in a fairly abstract way, but will go on to explore their potential application to the current research problem in the Discussion chapter.

A concrete example of the way in which hermeneutic realism – the philosophical position founded on the ontology of world-disclosure – can be used within qualitative health research is provided by Mol (2002, p. 5), who provides an example of plural, hermeneutic, realism, within the context of medical practice, depicting the patient's body as an object of multiple realities, multiply real. She proposes the foregrounding of practice, rather than of objects (such as the patient's body), as a means of understanding the plural realism of the body, which may be said to be all of these things at the same time: the patient's own animate form, the vehicle of disease, the archaeology to be examined by the radiologist, the

flesh to be dissected by the surgeon, and the site of wounds to be tended by the nurse. From this perspective, the world discloses itself differentially according to quality of our practical engagement with it, and according to what we know and are disposed to find meaningful.

Plural, hermeneutic, world-disclosing realism was selected as the ontological basis of the present study, since it was thought to provide a suitable framework for sense-making about the complex, intersubjective experience of osteopathy, which, may be viewed – as already described – as a "continual coming into knowing that does not resolve itself in either knowing or holding onto certainty as a consciousness" and "only exists whilst it is being performed, as it demands the mechanism of the patient's body and the osteopath at the same time" (McKone, 2001, p. vii). McKone's expressivist account depicts the osteopathic encounter as an intersubjectively shared phenomenon that reveals itself uniquely, only at the moment in time and in the particular place, when the patient and the osteopath are together (i.e. when the practice is given the foreground). The plural/hermeneutic realism outlined by Mol (2002) permits an ontological multiplicity that has the capacity to account for the phenomenon of cranial osteopathy as it is experienced both uniquely and intersubjectively by its practitioners and patients and as it can be understood by the onlooking researcher. For Willig (2013), a problem of this sort warrants a critical realist ontology – which hermeneutic realism represents – a proposition that permits an interpretation of the sense-making about the underlying worldly structures that generate the intersubjective experience of such a phenomenon.

Given that the research problem is concerned with intersubjective experience of a contested phenomenon, and that I – as researcher – have a distinctly hermeneutic disposition towards the issue at hand (having spent many hours cogitating on the ontic qualities of the mechanism of cranial osteopathy and the most suitable manner of discourse about it), the expressivist epistemological position of hermeneutic realism is more appropriate than either objectivist/positivist or subjectivist/relativist paradigms. Yanchar (2015, pp. 107-109) characterises hermeneutic realism as a middle ground situated between the epistemological poles of objectivism and subjectivism, not eschewing the reality of objects in the world, and neither positing that they are suprapersonal social constructs, but understanding that objects are only ever meaningful in their particular context. Yanchar (2015) follows Dreyfus and Spinosa (2006) in proposing that we humans are 'existential world-disclosers' rather than 'epistemic world-constructors', and extends this proposition to suggest the concept of 'world-disclosure' as a model for qualitative social research.

3.3. Theoretical Perspective and Methodology

Crotty (1998), Gray (2013), Willig (2013) and Green and Thorogood (2014) all recommend that qualitative social and health researchers, having considered their research paradigm and ontological and epistemological standpoint, then go on to establish their theoretical perspective in advance of establishing their research question and methodology. The research problem, as outlined above, is a praxial one concerning an understanding of the intersubjective experience of a contested phenomenon – cranial osteopathic therapeutic intervention – and the professional requirement to communicate about it (with patients, students, other healthcare professionals) with authority and candour. Although, as

explained above, I initially considered post-modern (such as Discourse Analysis) and constructivist (such as Grounded Theory) approaches to analysing the practice of cranial osteopathy, I came to understand that, as an 'insider' (Finefter-Rosenbluh, 2017), I would find it difficult to step aside from the research problem during the conduct of the study, and felt that the dissonance resulting from adopting an externalist stance would likely affect my ability to occupy the co-existing worlds of osteopathic practice and research simultaneously. A perspective that straddled both realist and interpretivist realms whilst resonating with the ontology of hermeneutic realism, such as phenomenology, was considered an appropriate alternative, and one that has recently been taken by researchers in the field of alternative and complementary health, as well as psychology and health professions allied to orthodox medicine (Holloway and Wheeler, 2010; Willig, 2013; Green and Thorogood, 2014).

As explained in the Literature review chapter, a phenomenological approach has been proposed for understanding the structure of medical and healthcare encounters as hermeneutic encounters (Daniel, 1986; Dekkers, 1998; Svenaeus, 2000a, 2000b, 2003; Tyreman, 2011). Svenaeus (2000a, p. 133) likens the patient-practitioner relationship to a Gadamerian merging of the horizons of understanding of the doctor and the client.[13] A phenomenological research method was therefore considered fitting for a model of healthcare praxis such as cranial osteopathy that, in McKone's account, is an enigmatic and intersubjective shared experience involving, perhaps, a merging of horizons. Several schools

[13] The concept of the *Horizontverschemlzung* has been described in the Literature review chapter.

of research methodology based on the phenomenological model are explored below, and attention is also paid to the criticisms of their detractors.

3.3.1. Phenomenological analysis

As Cassidy *et al.* (2011) and Øberg, Normann and Gallagher (2015) – within the field of physiotherapy – and Consedine, Standen and Niven (2016), Lee-Treweek (2002) and Orrock (2016) – within the field of osteopathy – demonstrate, phenomenological analysis research methods are an appropriate means of investigating how individuals experience and make sense of rich, complex, deep or novel experiences – such as, physical, pre-verbal, subtle, implausible or contested healthcare interventions. The reason for this is that its roots are in the philosophical tradition described above that engages with how phenomena – in whichever domain (i.e. dreams, illusions, sensations, objects, people, events) – appear to consciousness and how they come to be interpreted and understood.

As a qualitative research method, phenomenological analysis has two distinct traditions: descriptive/eidetic (after Husserl; Giorgi, 2007; Giorgi, 2011; Giorgi, 2017) or hermeneutic/interpretative (after Heidegger and Gadamer; Smith, Flowers and Larkin, 2009; van Manen, 2017a and 2017b). These two distinct traditions are now analysed.

3.3.2. Descriptive phenomenological analysis

The psychologist, Amadeo Giorgi, is known as the principle proponent of the intuitive, descriptive phenomenological method that follows in the Husserlian eidetic tradition of imaginative variation. Giorgi holds that the descriptive phenomenological method should

adhere to rigorous “scientific criteria” (Giorgi, 2011, p. 196), in order to secure its reputation in the arena of quantitative psychological research. Giorgi systematically adopts Husserl’s method known as the ‘phenomenological reduction’ – a parenthesisation of one’s naïve acceptance of the taken-for-granted world – in order to describe the phenomenological essence of the matter to-hand. Following Husserl, Giorgi sees no contradiction between the propositions that his analytical approach can be at the same time both “scientific” and “intuitive” (Giorgi, 2017, p. 98). He develops the later Husserl’s method of the ‘psychological reduction’ in order to intuit and articulate “the psychological understanding of what was lived through straight-forwardly by persons who did not necessarily anticipate a subsequent psychological analysis” (Giorgi, 2017, p. 126). According to this Husserlian tradition, a phenomenological analysis should aim “to capture experience in its primordial origin or essence, without interpreting, explaining, or theorizing” (van Manen, 2017a).

3.3.3. Hermeneutic phenomenological analysis

In contradistinction to the descriptive phenomenological method described above, there are other branches of phenomenological research tradition, informed by Heideggerian ontology and by the hermeneutic methods of Schleiermacher, Dilthey, Gadamer and Ricoeur (Smith, Flowers and Larkin, 2009, pp. 21-29). These are ontological phenomenology and Interpretative Phenomenological Analysis (IPA), which are explored below.

3.3.4. Ontological phenomenology

The pedagogue, Max van Manen, has applied phenomenological research methods to the practice of education and to the written practice of qualitative enquiry, and claims that “the

focus of phenomenology is on how phenomena are given to us in consciousness and pre-reflective experience" (van Manen, 2017b, p. 2). The word, 'given', used here, reflects the expressivist ontological perspective of phenomenologist and theologist, Jean-Luc Marion, who warns against a constructivist slant by emphasising the ontological givenness of phenomena, i.e., that the things we encounter in the world do not reveal themselves to us because we turn to them, but because they are already there (or 'given') (van Manen, 2017a, p. 775). Also of note is van Manen's proscription against a phenomenology of experience that is intra-reflective or post-reflective.

3.3.5. Interpretative phenomenological analysis

Interpretative Phenomenological Analysis (IPA) is a hybrid psychological research method developed by the health psychologist, Jonathan Smith, which has been used extensively as a qualitative research method in the fields of psychology, allied health and organisational studies (Eatough and Smith, 2017). Smith draws together the hermeneutic tradition exemplified by Schleiermacher, Dilthey, Gadamer and Ricoeur, with the phenomenological stance of Heidegger, to present a qualitative research method which he claims to be concerned with "the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience" (Smith, 2011, p. 9). He therefore proposes a method that differs in scope from the projects of both Giorgi and van Manen, outlined above. The distinctions are fine, but should be emphasised. Giorgi is primarily concerned with making psychological sense of the experience of his research participants by using a systematic approach to intuiting and describing what they say about their experience. Van Manen proposes that the phenomenological approach

involves not merely description but also interpretation of the lived experience of research participants (van Manen, 2017b), but does not countenance the notion that the reflective sense-making of participants about their experience can be the subject of phenomenological analysis.

Giorgi (2011) and van Manen (2017) both criticise Smith on the grounds that he has misinterpreted the phenomenological project, the former from the Husserlian perspective and the latter from the standpoint that IPA research projects tend to be more concerned with psychological explanations – rather than phenomenological understanding – of participants' accounts. Valid criticisms these may be, but there is one aspect of the IPA approach in particular that justifies its choice as a research method for the present project – its inclusion of the field of cognition, reflection and sense-making as a valid object of inquiry (Smith, Flowers and Larkin 2009, pp. 187-194; Larkin, Eatough and Osborn, 2011; Eatough and Smith, 2017, p. 202). If Sheehan (2014, p. 260) is correct in his interpretation that Heidegger intended 'meaning' (*Sinn* and *Bedeutung*) to be co-extensive with 'being' (*Sein*) in the ontology of *Dasein*, then the work of the human, 'thrown' (*Geworfen*) into a world of facticity, entails sense-making as the *sine qua non* of existing. The current research has at its heart a problem about the knowability and articulability of a complex embodied phenomenon (the intersubjective continual "coming into knowing" described by McKone (2001, p. vii)), and thus requires a research method that permits exploration of this epistemic field of enquiry.

Smith, Flowers and Larkin (2009) claim,

> "We consider the natural attitude of everyday experience [i.e. the mode of being when the world is taken for granted], which is the site for phenomenological inquiry, to have a wide spectrum or bandwidth and that it contains within it both pre-reflective and reflective activity"
>
> Smith, Flowers and Larkin, (2009), p. 188.

The authors specifically make a case that cognition "is and can be a significant site for phenomenological inquiry" (Smith, Flowers and Larkin, 2009, p. 191). For this reason, IPA is a suitable phenomenological research method for the current research problem.

3.4. Methodological Premises

3.4.1. Accounts of cognition

As outlined in the introduction, the accounts of cognition that arise from the research problem and inform the selection of the research method are those that are concerned with the realms of the cognition of 'animate forms' (Sheets-Johnstone, 2011), embodied consciousness (Varela, Thompson and Rosch, 2016), enactive cognition (Gallagher, 2005; 2017; Larkin, Eatough and Osborn, 2011) tacit knowing (Polanyi, 1961, 1962, 1966), 'felt experience' (Gendlin, 1997) and 'the background' (Shusterman, 2012; Dreyfus and Taylor, 2015).

3.4.2. Accounts of language

The originators of IPA have been criticised for taking no evident stance on linguistic theory as it pertains either to the speech or texts of IPA study participants or to the linguistic analysis employed widely in IPA data analysis (Willig, 2001; Paley, 2017). Cognitive linguistics (Greenspan and Shanker, 2004; Lakoff and Johnson, 1980a, 1980b and 1999; Sheets-Johnstone, 2011; Taylor, 2016; Trevarthen, 2015) is a loose ontogenetic theory of language that accommodates to the accounts of cognition set out above. It should be pointed out that not all of the cited authors use the name, 'cognitive linguistics', to describe their particular paradigm, but the term is used as a marker of distinction from Skinner's behaviourist and Chomsky's generative theories of language acquisition. Cognitive linguistics serves as a basis for the data analytical method employed in this research project and also, as will be demonstrated, scaffolds some of the project's findings. On a practical level, during data analysis, I followed the guidance of Smith, Flowers and Larkin (2009, p. 88) to take note of "pronoun use, pauses, laughter, functional aspects of language, repetition, tone, degree of fluency", as well as metaphor.

3.4.3. Accounts of the body

Despite the researcher's lean towards an expressivist ontology of hermeneutic realism (describe above), cranial osteopathic theory and practice were developed at a time (in the mid-twentieth century) and in a place (the USA) when the ontological assumptions of western philosophical discourse adhered to a Cartesian substance dualism that depicted being as the work of the body and thinking as the work of the mind. Cranial osteopaths talk about working with their patients as whole people, but also with the 'mechanism', or the

'intelligence', or the 'body' of their patients (Becker, 1997 and 2000). In my experience, osteopathic patients also accept this dualistic division, even though they might consider cranial osteopathy to be a 'holistic' therapy. In line with my position on cognition and the ontogenesis of language, I draw on an account of the body whose first premise is that it is neither brute matter nor a machine (Merleau-Ponty's *Körper* – or body as object), but rather the living medium of our Being-in-the-world (Merleau-Ponty's *Leib* – or body as subject). As outlined in the literature review, the writings of Merleau-Ponty (1962, 1968), Sheets-Johnstone (2011) and Shusterman (2008 and 2012) flesh out this premise.

3.4.4. Accounts of hermeneusis

Smith, Flowers and Larkin (2009, pp. 22-29) and Eatough and Smith (2017, pp. 195-196) provide an introduction to the holistic and historicist method of hermeneutics developed by Schleiermacher at the turn of the nineteenth century, then draw from Heidegger's notion that the very appearance of phenomena contains their potential for self-concealment and requires hermeneutic engagement for their meaning to self-disclose. They explore Gadamer's development of Heidegger's concept of the fore-structure (of which, further, below), and explain the practical concept of the 'hermeneutic circle', a framework used by Schleiermacher, Dilthey and Heidegger as a means of developing a dynamic, iterative, to-and-fro, particular-and-general appreciation of both the coherent sum and the individual parts of the phenomenon of interest. Using this circular approach, the hermeneut projects into the phenomenon of interest, withdraws, attends to their fore-structure, makes sense of the phenomenon's embeddedness in its context, whilst also abstracting it. This model of hermeneutic praxis informs the present project's research method, with 'the phenomenon'

being the crux of the research problem – i.e. sense-making about the lived experience of cranial osteopathy as it is shared by the patient and the osteopath.

Smith and Osborn (2007, p. 53) make use of a concept, the 'double hermeneutic', and propose it as a central principle in IPA. They use the concept in a way that diverges from the meaning of sociologist, Anthony Giddens, who used 'double hermeneutic' to explain the back-and-forth process of reciprocal understanding required by active social agents (Schwandt, 2007). Smith and Osborn (2007) instead use the concept of the 'double hermeneutic' to describe the process whereby the researcher interprets the research participant interpreting their lived experience: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith and Osborn, 2007, p. 53). I take the view that the double hermeneutic principle can be expanded into a multiple hermeneutic principle which takes account of both the sense-making undertaken by the research participant of the researcher, and also the multi-layered structure in which experience is considered co-extensive with hermeneusis (*Sein = Sinn* (Sheehan, 2014, 2015)). In my view, therefore, this last structure could therefore be formulated, 'the researcher tries to make sense of the participants making sense of their sense-making'.

3.5. Articulating the Research Problem

The consideration of methodological concerns, as presented above, led necessarily to further thought about how best to articulate the research question. My intention was to explore the intersubjective phenomenon that discloses itself to the cranial osteopath and

the patient as they participate with each other during a cranial osteopathic encounter. This translated into the research question, 'What sense do osteopaths and their patients make of the phenomenon of cranial osteopathy?' Inherent in this question is the multiple (double, double) hermeneutic: the osteopaths and patients making sense of their sense-making about/engagement in the therapeutic mode of being that is a cranial osteopathic treatment, whilst making sense of each other. IPA, with its explicit employment of the double hermeneutic and its accommodation of cognition as a warranted field of hermeneutic inquiry, was thought to be an appropriate methodological framework for this research question.

3.6. Methodological Choices

3.6.1. Study design

Certain methodological choices had then to be made. As outlined in the introduction, there is a paucity of evaluative literature on the impact, experience and effectiveness of cranial osteopathy. The initial plan was to undertake an evaluative topical review of cranial osteopathy that would be historicist and analytical of the literature according to its epistemological foundations. Greenhalgh *et al.* (2009), Greenhalgh *et al.* (2011), Gough (2013) and Greenhalgh *et al.* (2016) have developed guidelines and reporting standards for such a literature review, capable of surveying complex and contested topics of research that traverse different disciplinary boundaries: the meta-narrative literature review. There was a question as to whether to undertake the review prior to, post, or during the IPA study. For practical purposes, and even though it might have contributed significantly to the researcher's fore-structure, I decided to defer carrying out the review during the conduct of

the IPA study. As will be explained in the Research Methods chapter, the scale, scope and depth of the IPA study meant that I made the decision to postpone the much-needed – but resource-intensive – meta-narrative literature review of cranial osteopathy until after the IPA study was completed, and to alter the study design so that the literature review became a brief, introductory appraisal, as recommended by Smith, Flowers and Larkin (2009, p. 42).

I considered the use of multimodal and visual methods, which have been used in IPA studies to garner enriched data (Bacon *et al.*, 2017; Boden and Eatough, 2014), as a means of recording and analysing a cranial osteopathic treatment, but decided that the Hawthorne effect might apply, thereby distorting the trustworthiness of the data; it was also discounted on ethical grounds as potentially intrusive and disruptive of the patient-osteopath relationship.

Diary methods (Hyers, 2018) have been used in IPA studies (Sugden, 2013; Walker and Cross, 2018) and were considered as a pragmatic way of collecting data from participants who could record their insights about their experience of cranial osteopathy using their own language and in their own time (Finlay, 2011, p. 205); this was discounted on the grounds that the blank page might either prompt great introspection and an over-edited account, or might cause writer's block in the face of trying to express the ineffable.

The focus-group method was also considered – and could have involved a group of patients and a group of osteopaths (this method was used in an IPA study by Lamb and Cogan (2016) exploring resilience in mental health workers). The focus-group method could have been a practical way of examining how sense is made collectively about a phenomenon that is

difficult to articulate – but the disadvantage would potentially have been the lack of idiographic flavour, as dominant voices might have flattened the tenor of the discourse. There was also the ethical dimension to consider, particularly the risk that patients would feel pressurised to disclose facts about their health in the course of discussing the experience of cranial osteopathy.

Having discounted visual, multimodal, diary and focus-group methods for the reasons explained above, I concluded that in order to maintain the orientation of the study around the intersubjective sense-making of the phenomenon at hand – whilst minimising the risk of disrupting the therapeutic relationship – the most appropriate method would be a small-sample, dyadic IPA structure involving parallel but separate and confidential interviews. Such methods have been used to study the therapeutic relationship between psychotherapists and long-term clients (Haskayne, Larkin and Hirschfeld, 2014) and in a number of other studies that have explored dyadic relationships in the context of health (Maxted, Simpson and Weatherhead, 2014; Loaring *et al.*, 2015; Wawrziczny *et al.*, 2016). Face-to-face interviews were considered the least burdensome and most sensitive way of collecting data, and are thought to generate the most authentic responses from participants, "allow[ing] a rapport to be developed and giving participants the space to think, speak and be heard" (Smith, Flowers and Larkin, 2009, p. 57). A semi-structured interview method was selected as a means of maximising the depth, richness and homogeneity of the responses.

3.6.2. Sample and recruitment

I decided to recruit four osteopath-patient dyads (i.e. four pairs consisting of an osteopath and a patient of theirs) – a sample-size used successfully in the study by Haskayne, Larkin and Hirschfeld (2014). This number was thought to be logistically manageable, whilst at the same time providing a range of voices as a source for exploring a hitherto under-researched field of enquiry. There were ethical concerns about asking osteopaths to recruit patients of theirs to participate in the study (these are explored in detail in the Research methods chapter), but to mitigate against these I decided to interview each member of the dyad individually and confidentially. The risk of disrupting the therapeutic relationship was mitigated by ensuring, via the recruitment criteria, that the osteopaths invited patients they knew well, and believed would be happy to give of their time to talk about their lived experience of cranial osteopathy. These considerations are explored in the Research methods chapter, which follows.

3.6.3. Data collection

I decided to ask the participants to recount their experience in a spontaneous and unedited way (in 'the natural attitude'). As Smith, Flowers and Larkin (2009, p. 12) explain, the 'natural attitude' is the perceptual mode in which most beings are said to encounter their world, most of the time. It is unreflective and quotidian and permits us to engage with objects, experiences and others without questioning their ontological basis. I planned to interview the participants in a way that would capture immediate reflections 'naturally', so as to generate data that emerged from the line of questioning in a relatively flowing way

(Finlay, 2011, pp. 199-201; Smith, Flowers and Larkin, 2009, pp. 64-66).[14] The osteopath and patient interview schedules were designed with a parallel content, following the practice of Loaring *et al.* (2015) and were piloted with both experienced cranial osteopaths and volunteers unconnected with the study who had no experience of cranial osteopathy.

The interview schedule and process were planned so as to follow best-practice guidelines for qualitative research data-collection (Green and Thorogood, 2014; Holloway and Wheeler, 2013), posing open questions, with a neutral tone and few prompts other than repeating requests for further insight (further details are given in the Research Methods chapter that follows). The interviews were planned to be characterised by the use of open and non-leading questions, verbal and non-verbal (gestural and vocal) prompts, tonal neutrality, along with short spells of silence during which participants collect their thoughts. This open and neutral approach was designed to support the generation of data that was 'natural', authentic and unskewed by any explicit input or approval by the interviewer. This approach occupies the centre ground identified by the philosopher, Paul Ricoeur, as the midpoint between critical and empathic modes of engagement (Shinebourne, 2011, p. 21).

Alternative methods of data collection were considered, but the use of telephone or teleconferencing technologies is thought to create a distancing barrier between the participant and the interviewer, with minute delays and the absence of clear visual clues

[14] I explain the challenges that this represented, given the study's focus on sense-making about sense-making, in the Discussion chapter.

leading to problems with the natural flow of turn-taking and therefore creating self-consciousness in both parties (Lo Iacono, Symonds, and Brown, 2016). The use of asynchronous epistolary modes of communication creates a temporal delay during which participants are more likely to depart from their natural attitude and enter a state of self-reflection that leads to self-editing and a revisioning of their account (Smith, Flowers and Larkin, 2009, p. 57).

3.6.4. Data analysis

There have been general criticisms of some IPA studies on the grounds that the methods of data analysis have been overly formulaic, insufficiently interpretative, apparently end-gaining, neglectful of declaring the interpretative stance and role of the researcher, and too far removed from the phenomenological methods that inspired IPA – whether in the descriptive tradition or the hermeneutic tradition (Brocki and Wearden, 2006; Giorgi, 2011; Smith, 2011; van Manen, 2017a). Having considered the methodological guidance presented by Smith, Flowers and Larkin (2009), attended several IPA methodology training sessions (see Appendix 2) and read the aforementioned critiques of the IPA, I made the following commitments:

- To be rigorous in examining and accounting for my fore-structure, which included an explicit ownership of my theoretical and praxial co-understanding, which naturally developed during the hermeneutic process (see below).

- To develop a systematic framework for the process of data-analysis (see below and Appendix 3) which nonetheless permitted scope for an intuitive engagement with the sense-making of the participants.
- To retain a phenomenological ontological perspective and language that would reflect this (e.g. avoiding constructivist terms, such as 'coding', 'constructing themes' and 'data-saturation').
- To transcribe the participants' accounts myself and to undertake an imaginative, multi-layered and iterative reading of them with a conception of the hermeneutic circle as a complex holosphere, rather than a two-dimensional device.

The hermeneutic method of data analysis was influenced by Ricoeur's reading of Heidegger's hermeneutic ontology:

> "The first function of understanding is to orientate us in a situation. So understanding is not concerned with grasping a fact but with apprehending a possibility of being. We must not lose sight of this point when we draw the methodological consequences of this analysis: to understand a text, we shall say, is not to find a lifeless sense which is contained therein, but to unfold the possibility of being indicated by the text."
>
> Ricoeur (2016), p. 17.

This involved embodying a situational empathy – a 'concernful involvement' (Yanchar, 2015) – with the sense-making of my participants, and was achieved through an ongoing recourse

to the theoretical and praxial aspects of my fore-structure, which primed and framed my phenomenological attitude as I undertook the phenomenological reduction (which I describe below).

3.6.5. The role of theory in IPA Studies

It is necessary to say a word or two about the role of theoretical fore-understanding in IPA, particularly in light of the criticism of phenomenology as a research method by Paley (2017), which has been rebutted in lengthy counter-critiques by Giorgi (2017) and van Manen (2017b). From an evidently empiricist standpoint, and giving little sense of understanding the philosophical method of phenomenology, Paley (2017, pp. 9-41) decries the failure – as he sees it – of Giorgi, van Manen and Smith to explain their process of 'meaning attribution' (the term he uses for the phenomenological concept that is variously known as 'hermeneusis', 'interpretation', 'disclosure' or 'unconcealment' in the phenomenological tradition (Dreyfus, 1980; Wrathall, 2011)). He is particularly concerned about the problem of pre-existing theory as an unacknowledged influence on the meaning that phenomenological researchers make of their texts. Paley pays little heed to concepts and analytical methods such as the phenomenological reduction, the multiple hermeneutic, the hermeneutic circle and the constructive engagement with one's fore-structure – all of which are ways of handling the influence of pre-existing knowledge, with nuance, and enable the researcher to generate theoretical ramifications and modifications in the course of their study.

Other critics such as Brocki and Wearden (2006) also note of early IPA papers that there is sometimes a failure to acknowledge the role that theoretical orientations and

underpinnings have played in the data analysis and conclusions. More recently, Eatough and Smith (2017, pp. 199-200) have urged IPA researchers to resist 'top down interpretations' and the importation of theory before the researcher "has had the chance to dwell with the data and work towards disclosing meaning". In the present research project, my aim as researcher was to find a way of coming to terms with my assumptions, predispositions, theoretical foundations and prejudices, in order that I could 'suspend' them whilst 'dwelling' with my data. This important matter is dealt with further in the final two sections of the Methodology chapter.

3.6.6. Rigour

The study was designed in accordance with the Standards for Reporting Qualitative Research (SRQR) recommendations by O'Brien *et al.* (2014), which contain twenty-one standards, all of which are addressed in this thesis report. As demonstrated in the Research Methods chapter, there was an attempt to meet the quality standards suggested by Larkin and Thompson (2012), Polkinghorne (1983) and Smith (2011). Additionally, the study was designed to answer the dilemmas posed by Yardley (2000, p. 219), which are widely cited as principles underpinning high-quality qualitative research-design. They are adapted in the table below, with the second column containing evidence of the way in which the present study is thought to meet Yardley's criteria (see Table 2).

TABLE 2 EVIDENCE THAT STUDY MEETS QUALITY STANDARDS OF YARDLEY (2000)

Characteristics of good qualitative research Yardley (2000)	**Evidence afforded by the present study**
Sensitivity to context	• Research problem has arisen from a praxial situation • Study is designed to relate to existing theory and literature, but to respond to a significant gap • Study is committed to interpreting and conveying the idiographic voices of its participants • Ethical considerations have been addressed and risk mitigated
Commitment and rigour	• The study has been designed to support an in-depth engagement with the research problem • The researcher has developed the skills and experience to undertake the research competently • Data analysis is detailed, has multi-layered depths and, while not broad in scope, has the potential to reach across its disciplinary borders
Transparency and coherence	• Methods are described in fine detail • Participants have audited their transcripts • Supervisory team has audited data analysis • Researcher fore-structure and phenomenological attitude are addressed, accounted for and cited • The method selected has coherence with the subject of study
Impact and importance	• The findings of the study are important for healthcare practitioners who use physical contact in their practice • The findings have the potential to improve osteopath-patient communication and the acquisition of consent • The results of the study contribute to a new theory of practice in the fields of physical, manual, somatic and psychological healthcare.

3.7. Researcher Reflexivity, Fore-structure and Phenomenological Reduction

As this chapter began with a reflexive introduction to the research problem, so it ends with an explanatory framework that accounts for the role of the researcher in the current study. I maintained a reflexive research journal from the initial conception of the study and engaged in correspondence with my academic and osteopathic peers as a way of coming to terms with the nub of the problems I faced in articulating, designing and conducting the current study. The project, aiming towards achieving a professional doctorate, has throughout its course retained its praxial relevance, and I acknowledge my contribution to this trend with quotations from my reflexive journal (Appendix 4) and with an evaluation of the role my praxial and theoretical fore-structure (or fore-understandings) played in the conduct of the study found in the Discussion chapter.

I came to understand the concept of a fore-structure by reading Dahlberg, Drew and Nyström (2001), Dreyfus (1980) and Smith, Flowers and Larkin (2009); I developed the following explanation, articulating the role my fore-structure played in my hermeneutic holosphere and in my undertaking of the phenomenological reduction (i.e. the commitment to remain open to the phenomenological meaning of my participants' lived experience), and to therefrom reflect on the "basic structures of the lived experience of human existence" (van Manen, 2017a, p. 777). The fore-structure is a metaphor for our pre-understanding or fore-understanding – the totality of our situatedness in our Lifeworld. Dreyfus (1980) identifies three components in his reading of Heidegger:

1. *Vorhabe* (fore-having) – the "totality of cultural practices" in which we are enmeshed that "thus determine what we find intelligible".
2. *Vorsicht* (fore-sight) – "the vocabulary or conceptual scheme we bring to any problem"; our theoretical understanding.
3. *Vorgriff* [Dreyfus does not translate it, but it makes sense as 'pre-apprehension'] – a specific hypothesis which, within the overall theory, can be confirmed or refuted.

Dreyfus (1980), p. 10.

Gadamer and Merleau-Ponty also contribute to the concept of the fore-structure employed in the current project. Gadamer uses the word, *Vorurteil*, which can be translated as 'prejudice' (Dahlberg, Drew and Nyström, 2001, p. 83), and exhorts against unconscious domination of the philosopher/researcher by their historical and cultural circumstances. Merleau-Ponty (cited by Dahlberg, Drew and Nyström, 2001, p. 124) presents a typically poetic metaphor for accounting for the researcher's fore-structure in the process of undertaking the phenomenological reduction. He says:

> "[the philosopher] must suspend the affirmations which are implied in the given facts of his life. But to suspend them is not to deny them and even less to deny the link which binds us to the physical, social and cultural world. It is on the contrary to *see* this link, to become conscious of it."

Merleau-Ponty (1964), p. 49.

Merleau-Ponty (cited by Dahlberg, Drew and Nyström, 2001, p. 125) also exhorts the philosopher to have a reflective stance that does not withdraw from the world, since

> "[reflection] steps back to watch the forms of transcendence fly up like sparks from a fire; it slackens the intentional threads which attach us to the world and thus brings them to our notice."
>
> Merleau-Ponty (1962), p. xv.

This last metaphor provides a resonant analogy for the hermeneutic lens with which I addressed the research problem, given its origin in my professional praxis and my insider-perspective as researcher. The following quotation is a rumination on my fore-structure, extracted from my reflexive research journal:

> "My Vorhabe is the space and time into which I have been thrown, meaning that I have been able to train and practice as a private health-care practitioner and live in a relatively affluent part of the world where people appreciate me and make use of my services.
>
> My Vorsicht is composed of my developing understanding of the mechanisms at play within the cranial osteopathic encounter (I am developing my understanding by a) exploring the lived experience of my participants, b) reading lots, using an opportunistic search method, c) reflecting on my own praxis).

> My Vorgriff is my attachment to the idea that the cranial osteopathic encounter is structurally/existentially an inter-subjective, situated, inter-corporeal, enactive encounter that is meaningful to its participants and therapeutic in the sense that is nurturing and supportive of the patient/consociate coming-to-terms-with their spatio-temporal thrownness (their eccentrically radiating sense of adjustment to themselves in the fullest sense of what a self is – from unverbal feelings within, to embodied manifestations of physiological or psychic events within the health-unhealth spectrum, to their sense of Anshin[15] within their ecological environment). I am calling this type of encounter, 'aesthetic engagement'.
>
> I hold these fore-frames ahead of me so that I am able to look through them whilst engaging with my participants' interpretation of the phenomenon (and of their interpretation of their interpretation of the phenomenon, i.e. when they adopt the phenomenological attitude)."

(Reflexive Journal, 22 April 2018).

I demonstrate ongoing attention to my fore-structure throughout the course of this thesis, and reflect on it in detail within the Discussion chapter.

[15] Japanese word indicating an ease-of-mind or a sense-of-safety/security.

3.8. Chapter Summary

In this chapter, I have explored the philosophical and praxial context of the research problem and have given an account of the ontological stance of hermeneutic realism that underpins the present study. I have discussed the interpretative theoretical perspective that accords with my ontological stance and introduced the specific phenomenological paradigm which holds that 'Being-in-the-world' and 'meaning' are co-extensive. I have evaluated different phenomenological research methods and have justified the choice of IPA as an apt method with which to address my research question. I have outlined the steps I have taken to maintain academic and professional rigour and I have also justified my approach towards my fore-structure – to suspend it before me, without attempting to set it aside.

CHAPTER 4: RESEARCH METHODS

4.1. Chapter Introduction

This chapter sets out in detail the research methods employed, and the study design developed, in order to meet the aims and objectives of the research project. It covers the practical and ethical considerations and the analytical methods used.

4.2. Aims and Objectives of the Study and Research Questions

The aims of the study were:

1. To explore cranial osteopaths' understanding and lived experience of the theory and practice of cranial osteopathy, with reference to a series of therapeutic encounters with one of their patients.
2. To explore patients' understanding and lived experience of the theory and practice of cranial osteopathy, with reference to a series of therapeutic encounters with their cranial osteopath.

The objective of the study was to conduct a dyadic Interpretative Phenomenological Analysis (IPA) of the interpretation that pairs of cranial osteopaths and their adult patients make of the phenomenon of cranial osteopathy.

The principal research question was, 'What sense do cranial osteopaths and their patients make of the phenomenon of cranial osteopathy?' The question was phrased in this manner reflecting a model of osteopathic medicine rooted in the perception of healthcare as a phenomenological practice – a hermeneutic and intersubjective endeavour (Daniel, 1986;

Dekkers, 1998; Svenaeus, 2000a, 2000b and 2003). Understanding and experiencing the phenomenon of cranial osteopathy is viewed as 'making sense', or interpreting, the theory and practice of cranial osteopathy. As presented in the previous Methodology chapter, theory and practice are considered to be mutually enfolded, from the ontological standpoint of Heideggerian phenomenology which informs this project. As discussed in the Methodology chapter above, lived experience and understanding are considered to be co-constitutive and equivalent (Sheehan, 2014, p. 260). The term 'making sense' reflects the idea that humans work at *comprehending* – with its embedded sense of 'grasping' – theory and practice jointly by simultaneously living and understanding their experiences. Throughout this chapter, the terms, 'making sense' and 'sense-making', refer to the process of coming to terms with lived experience in a world of meaning. These terms also stand for the combined concept of 'experiencing and understanding', which is meant to imply that 'comprehension' of Lifeworld phenomena involves a combined process of embodied 'grasping' and 'making reflective, conceptual sense of' that which happens to us.[16] The related term, 'meaning-making', is used to suggest the product of sense-making – when significance and symbolic content arise from the process of sense-making.

[16] See etymological origins of the words, "experience", "understand", "comprehend", "grasp", "conceive", "cogitate", "reflect" which all have buried within them an embodied, physical (or manual) seed of meaning. Oxford Dictionary of English (2010), 3rd edn.

The research question had several components:

a) What sense do osteopaths make of the phenomenon of cranial osteopathy?
b) What sense do patients make of the phenomenon of cranial osteopathy?
c) What sense do osteopaths and their patients jointly make of the phenomenon of cranial osteopathy, particularly the phenomenon they share within the context of their unique osteopathic encounters?

4.3. Summary of the Study Design

The research question was addressed using the hermeneutic, qualitative research methodology, Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009). As the study was concerned with the sense-making undertaken by pairs of osteopath-patient participants within a series of cranial osteopathic encounters, the participants were cranial osteopaths and patients of theirs who have accessed cranial osteopathic treatment.

The issue at question here is the 'phenomenon' of cranial osteopathy, and how it is experienced and understood by those who practice and receive it. Within IPA – and owing to its roots within twentieth-century, 'continental' (i.e. European) philosophy – the term, 'phenomenon', refers to an object, experience or concept that reveals itself to consciousness (Smith, Flowers and Larkin, 2009, pp. 23-24). For the purposes of this project, 'cranial osteopathy' refers to the whole experience of the therapeutic interchange between cranial osteopaths (i.e. those who self-define as such) and their patients (i.e. those who understand themselves to be recipients of a therapy known as 'cranial osteopathy'). The aim

was to use a phenomenological approach to explore the lived experience of cranial osteopathic encounters. The term, 'lived experience', refers to the pre-reflective understanding that an individual has of a phenomenon that they are encountering or have encountered – in this case, cranial osteopathy. The study did not aim to explore whether particular osteopathic techniques were used, or to consider their effectiveness, nor did it aim to describe patient outcomes. Its focus of interest was sense-making about the phenomenon, as it had been experienced, according to the accounts of the participants.

Four osteopaths and a patient of each of theirs were interviewed individually and confidentially in order to generate the data illustrating the lived experience of osteopaths and their patients making sense of the phenomenon of cranial osteopathy. The data-set therefore consisted of transcriptions of the eight semi-structured interviews, audio-recorded by digital voice recorder. As researcher, I maintained a reflexive, hermeneutic involvement with the transcripts (supported by my academic peers and supervisory team). My reflexive stance as researcher was recorded and challenged throughout the research process, ensuring that personal perspectives were acknowledged and accredited. In addition to maintaining a reflexive research journal from May 2015, I audio-recorded a 'stream-of-consciousness'[17] account of my evolving understanding after each interview. The role of researcher reflexivity is explored further in this chapter, below.

[17] "The continuous flow of sense-perceptions, thoughts, feelings, and memories in the human mind; or a literary method of representing such a blending of mental processes in fictional characters, usually in an unpunctuated or disjointed form of interior monologue." Oxford Dictionary of Literary Terms (2015), 4th edn.

The initial plan was to pair the IPA with a meta-narrative literature review, but, once the extensive scope of the analysis had become apparent, in March 2017, it was decided to amend the literature review design according to the advice of Smith, Flowers and Larkin (2009), pp. 42-43, so that it would be brief, introductory and evaluative, rather than systematic and comprehensive (see Appendix 5).

4.4. Population and Sample

I am a UK-based osteopath trained in cranial osteopathy with the Sutherland Cranial College of Osteopathy, and became a Fellow of the College in 2014. The research question emerged during praxial reflection on the problem of communicating with patients about the phenomenon of cranial osteopathy. In keeping with the IPA stance on the insider hermeneutic lens, the osteopath participants were Fellows of the Sutherland Cranial College of Osteopathy (FSCCO). The patient participants were patients of the participating FSCCO. As argued in the Methodology chapter, above, the 'insider perspective' of the researcher is consistent with the phenomenological position on intersubjectivity (Fuchs and de Jaegher, 2009). The rationale for inviting cranial osteopaths and their patients to participate in the study was that IPA study participants should have both 'expertise' in the phenomenon to be analysed and relative 'homogeneity' (Smith, Flowers and Larkin, 2009, pp. 48-50). 'Expertise' refers to the participants' depth of experience with the phenomenon to be analysed – in the case of the present study, their experience as FSCCO who practised cranial osteopathy or as patients of such osteopaths. 'Homogeneity' refers to the participants all sharing, to a broadly comparable degree, the characteristic of either practising cranial osteopathy or experiencing it as a patient.

4.5. Sampling Strategy

In keeping with the phenomenological method of the study, recruitment was purposive, with the aim of attracting the interest of cranial osteopaths who met the study inclusion/exclusion criteria. It was anticipated that osteopaths who found the study topic of interest, and who therefore choose to reply to the invitation, would be, by definition, suitable participants in the study.

Given the idiographic quality of IPA studies, it was acknowledged that there could be no claims as to the generalisability of the study's findings, and, consequently, the sample size was aptly small. The study population of four osteopath-patient dyads was sufficiently large to enable different idiographic perspectives to emerge from the analysis, but not so large as to sacrifice depth of engagement. Informed by the design of recently published dyadic IPA studies (Haskayne, Larkin and Hirschfeld, 2014; Loaring *et al.*, 2015), the study aimed to recruit four-five osteopath-patient dyads, in order to best ensure four complete dyadic data-sets.

The justification for aiming to recruit five pairs of osteopaths and their patients was to allow for the possibility that participants might withdraw from the study. As the aim was to analyse four sets of osteopath-patient dyadic data, there would still remain four data-sets, should a participant have decided to withdraw. None of the initial eight participants chose to withdraw, and it was therefore deemed unnecessary to ask the fifth osteopath volunteer to continue with the project (see the section on ethical considerations within the present chapter, for further discussion).

4.6. Eligibility Criteria

The inclusion and exclusion criteria for the potential osteopath and patient participants are explained below.

4.6.1. Inclusion criteria – osteopaths

Potential osteopath participants were required to meet the following inclusion criteria, which meant that they were:

- Fellows of the Sutherland Cranial College of Osteopathy.
- Currently registered to practice as osteopaths in the UK.
- Willing to consent to participate in the study, and therefore also willing to recruit a patient of theirs to participate too.

Inviting FSCCO to participate meant that the researcher shared (to a certain extent) an education, heritage and praxis with the participants, compared with, for example, cranial osteopaths who had trained in different traditions (e.g. Upledger or biodynamic schools).[18] Participants in the study were required to be 'expert' in the sense that they had ample experience and understanding of their praxis as cranial osteopaths, and informed of the aims of the study, and at the same time open to being interviewed in a 'natural attitude' – a term derived from the philosophical practice of phenomenology indicating that they were

[18] Upledger CranioSacral Therapy was developed by an osteopath, John Upledger, and is taught to complementary therapists, as well as to regulated professionals such as nurses and physiotherapists (Upledger Institute, no date). Biodynamic osteopathy is a form of cranial osteopathy developed by an osteopath, Jim Jealous, that emphasises working with a 'higher wisdom' and the 'Soul of Osteopathy' (Jealous, no date).

not in a state of anticipative preparedness prior to the interview to provide comprehensively articulated statements about their experience and their beliefs.

4.6.2. Exclusion criteria – osteopaths

The study population excluded FSCCO who were members of the Research Sub-Committee, of which the researcher was also a member. Members of the SCCO Research Sub-Committee might have sufficient passing awareness of the aims of the present project to mean that they would not be suitable participants. As an extra precaution, I stood down from the Research Sub-Committee during the conduct of the study.

4.6.3. Inclusion criteria – patients

Potential patient participants were required to meet the following inclusion criteria; meaning that they were:

- Adult patients (aged 18 or over) of osteopaths who had agreed to participate in the study.
- Patients who had attended the osteopath for cranial osteopathy on five or more occasions.
- Willing to talk in some depth about their experience of cranial osteopathy.
- Willing to consent to participate in the study.

As the study was concerned with the lived experience of patients who were sufficiently interested in the phenomenon of cranial osteopathy to wish to talk about it in an interview, it was judged that those invited would have, *ipso facto*, consulted their osteopath on five or

more occasions. The duration of the therapeutic relationship, the nature of the symptoms addressed and the degree to which the patient had benefited from seeing the osteopath were not important for the purposes of recruitment to this study. What was at issue was whether the participant was sufficiently interested in their experience of the phenomenon of cranial osteopathy to shed light on it for the purposes of in-depth qualitative investigation.

4.6.4. Exclusion criteria – patients

Potential patient participants who were known to me as a patient or on a personal level were excluded. Interviewing a patient participant known to the researcher as a patient would have presented an unacceptable risk to the therapeutic relationship between the two parties. Interviewing a patient participant known to the researcher on a personal level would potentially have compromised my ability to retain a 'phenomenological attitude' – i.e. an interpretative stance – during the interview process.

4.7. Recruitment

The initial invitation was sent to the FSCCO, using electronic mail (see Appendix 6). Letters were sent by post to potential osteopath participants who replied to the initial invitation (see Appendix 7, Appendix 8, Appendix 9). The first five who met the inclusion/exclusion criteria, and who replied with their consent to proceed with the study were thanked and asked to invite adult patients of theirs who met the inclusion/exclusion criteria to participate. This they did by sending a covering letter (see Appendix 10) with a pack from the researcher (see Appendix 11 and Appendix 12). The first five osteopaths who returned

consent forms indicating their agreement to participate were sent acknowledgement letters (see Appendix 13).

Potential patient participants were invited to contact the researcher or Director of Studies to find out more about the study, or, had they no questions, to return the consent form. Those who agreed to participate were sent an acknowledgement letter thanking them for consenting to participate (see Appendix 14). Any additional respondents were thanked for their interest, and it was explained that the requisite number of participants had already been recruited (see Appendix 15). The process of participant recruitment is set out at Appendix 16.

4.8. Developing and Piloting the Interview Schedule

Consideration was given to using an unstructured interview format, but, after reflecting on of the aims of the project, and the goal of ensuring both depth and breadth of experience and understanding of the phenomenon of cranial osteopathy, a semi-structured interview format was developed (see Appendix 17). The schedules were piloted with two cranial osteopaths who were unconnected with the study, in April and May 2016, with minor adjustments made to the order of questions. They were altered again during the project approval process in June 2016, when the then British School of Osteopathy's Research Ethics Committee suggested that a question about understanding of the theory and experience of the practice of cranial osteopathy should be split into two separate items.

4.9. Project Approval

The project was approved by the University College of Osteopathy (known at the time as the British School of Osteopathy) on 14th June 2016 (see Appendix 18), and by the University of Bedfordshire's Institute of Health Research on 17th June 2016 (Appendix 19).

4.10. Ethical Considerations

4.10.1. Code of research ethics

The code of research ethics that informed the design and conduct of this study was that of the Research Ethics Committee of the British School of Osteopathy (now known as the University College of Osteopathy (UCO, no date c), which, in turn, was informed by two sources: 1) The research governance framework for practising osteopaths in the UK (National Council for Osteopathic Research, 2016), 2) Central Office for Research Ethics Committees (COREC) of the UK National Health Service (NHS), which is now known as the UK NHS Health Research Authority's Research Ethics Service. The principles underpinning the research ethics code that applies to the present study are based upon the rights, safety, dignity and well-being of participants who volunteer their involvement in research projects. I outline below how the conduct of the project was designed to safeguard the rights, maintain the safety, respect the dignity and reduce the risk of compromising the well-being of the participants in the study.

4.10.2. Risk of harm to participants

This study presented a low, but not negligible risk, to participants. The risk of harm pertained to questions in the interview which might have inadvertently provoked

introspection or emotional/psychological distress. It was possible, for instance, that a patient participant might reflect upon some aspect of their health or treatment that generated a painful memory, or that an osteopath participant might, on reflection, come to question some of their communication practices or treatment choices. These risks were described in the osteopath and patient participant information sheets. The mitigation for these risks included offering the participant the chance to withdraw without further explanation, but also advising them to discuss their concerns or feelings with their osteopath, other health professional or the researcher (in the case of patient participants) or with a trusted colleague or the researcher (in the case of osteopath participants).

Another potential risk was that participants might reveal information suggestive of professional malpractice. The risk was low, given that participants were volunteering to talk about their insights into a phenomenon of interest to them, and the interview questions did not intentionally lead the participants to consider aspects of professionalism. As a registered osteopath, bound by the Osteopathic Practice Standards, I am required to follow the Code of Practice Standards specified in C9:

> "1. You should take steps to protect patients if you believe that a colleague's or practitioner's health, conduct or professional performance poses a risk to them. You should consider one of the following courses of action, keeping in mind that your objective is to protect the patient:
>
> 1.1. Discussing your concerns with the colleague or practitioner.

1.2. Reporting your concerns to other colleagues or the principal of the practice, if there is one, or to an employer.

1.3. If the practitioner belongs to a regulated profession, reporting your concerns to his or her regulatory body (including the GOsC if the practitioner is an osteopath).

1.4. If the practitioner belongs to a voluntary council, reporting your concerns to that body.

1.5. Where you have immediate and serious concerns for a patient, reporting the colleague to social services or the police."

General Osteopathic Council (2012).

Had any indications of professional malpractice arisen during the course of the study, I would have been required to follow the steps above. No such indications arose during the conduct of the study.

4.10.3. Risk to the therapeutic relationship between osteopath and patient

Another potential ethical risk was that the therapeutic relationship between the osteopath participants and their patients might in some way become compromised as a result of the introspection arising from the interview. Although this was not a trivial risk, it should be contextualised by the potential threat that osteopath-patient relationships might suffer through exposure to poor publicity about osteopathy in the press (e.g. Mohammadi, 2015),

or through conversations or research that the patients might undertake in the normal course of events. Additionally, osteopaths are required to be reflective practitioners (see General Osteopathic Council (2012); Standard of Proficiency B2 and B4) and are likely to have had to hand the personal and professional resources needed to digest any discomfort that could have arisen as a consequence of participating in the project.

4.10.4. Risk to the Researcher

There was also a potential risk to the personal safety of the researcher, when entering a participant's home to interview them. The risk to my personal safety from my peers (osteopath participants) was deemed very low indeed. The risk of entering the homes of patient participants was similarly low, but was mitigated by adhering to the principles articulated by the Suzy Lamplugh Trust (no date), including:

- Informing the Director of Studies of the name and address of the participants whose homes would be visited by the researcher, alerting him to the date and time of the interview.
- Texting the Director of Studies at the start of the interview, stating the anticipated duration of the interview; texting again after leaving the house.
- Carrying a personal safety alarm.
- Trusting instincts.

There were also psychological risks, given that the interview questions were about the experience of embodied practice, and it was possible that uncomfortable threads of conversation might have emerged (Lee-Treweek and Linkogle, 2000). These potential risks were mitigated by interview-scenario role-play planning undertaken with my Director of Studies in February 2017. No uncomfortable or risky scenarios arose during the conduct of the interviews.

A further risk envisaged was that patient participants might have viewed me as an osteopathic practitioner and sought advice during our interviews about their health problems. This risk was mitigated by a statement in the patient information sheet and by an introductory statement prior to the start of the interviews. No participant requested any health advice during the course of the study.

4.10.5. Risk of coercion to participate

It was considered possible that potential participants would feel under pressure to participate; osteopaths because they believed they had a duty to participate in a research project even though this project was not of interest to them; patients because they wished to please their osteopath and feared a rupture in the therapeutic relationship if they refused the invitation to participate. To mitigate this risk, all communication with potential participants, both written and oral, was considered carefully to ensure that potential participants understood their participation would be entirely voluntary, and their consent could be withdrawn at any stage up until the time the transcript of the interview had been approved (see sections on valid consent and the right to withdraw, below).

4.10.6. Potential osteopath participants

As researcher and FSCCO I was a peer of the osteopath participants, sharing an educational, cultural and praxial heritage with them. Given my insider-status (Finefter-Rosenbluh, 2017), I shared a collegial acquaintance with some of the osteopath participants. This level of acquaintance was deemed unavoidable and acceptable. There were no incentives to participate beyond the potential for satisfaction at contributing to a research project within their professional field. I had no influence or authority over the potential osteopath participants. The osteopath participants were encouraged to speak to the Director of Studies or to me to gain more information about the study before agreeing to participate. One chose to do this, and I was able to supply further information about the aims and methodology of the project, leading to that osteopath agreeing to participate.

4.10.7. Potential patient participants

I did not know the patient participants in advance of the study. Patient participants were encouraged to discuss any issues or concerns they anticipated arising as a consequence of taking part in the study with their osteopath or other healthcare practitioners. They were encouraged to speak to the Director of Studies or to me to gain more information about the study before agreeing to participate. None took up this invitation.

4.10.8. Valid consent

Potential participants were advised that, having expressed interest in participating, they had at least two weeks from receiving the invitation letter to decide whether or not to participate in the study. It was possible that potential participants may have had learning

disabilities and, if this had been the case, they may not have chosen to disclose them. What was at issue was whether they had the capacity to give consent to participate in the project. Consent required actively reading the participant information sheets and choosing to sign the consent form (see Appendix 20 and Appendix 21), and returning it through the post. Prior to active participation in the interview, I ensured that consent had been given voluntarily by each participant who had understood what was entailed in taking part, meaning that consent was therefore valid.

As mentioned above, one osteopath requested further information before agreeing to participate, in November 2016. The other osteopaths agreed to participate after receiving the participant information pack, in December 2016. They recruited the patient participants according to the recruitment protocol in January-February 2017. The interviews were carried out in February-April 2017. I began every interview by explaining the purpose of the project, outlining the study design, ensuring that valid consent was gained and explaining the right to withdraw.

4.10.9. Right to withdraw

All participants were informed that they had the right to withdraw from the project without detriment up to the point when the transcribed data had been analysed and cited in the thesis. They were reminded that they could actively withdraw their participation when they viewed the transcript of their interview, and would be given two weeks from the date of receipt to request any emendations after reconsidering the way they articulated their thoughts during the interview (see Appendix 22).

Having received the transcripts of their interviews in May-July 2017, no participant had indicated anything other than approval to proceed by the time the data analysis began in October 2017.

4.10.10. Confidentiality and anonymity

In a project such as this, it was possible for anonymity and confidentiality to be compromised. Ongoing care has been taken to ensure the following:

- Personal information and all data have been collected and stored strictly in accordance with the principles of confidentiality and data security. Ethical and legal practice has been followed and all information provided by participants has been handled in confidence.
- All information pertaining to the project is to be stored securely for six years following the completion of the project, and will be destroyed after this time.

There was the risk that personal, identifying features might be revealed inadvertently in the interview. The participants were advised to avoid mentioning personal, identifying features, but were also informed that, should this occur, these details would be blanked out by the researcher who would be transcribing the interviews personally.

Osteopath participants were assured that their name would not be recorded on the transcript, nor would it be mentioned in the final report, and that only the researcher and Director of Studies would know of their identity. Osteopath participants would know that

their patients were participating, and were asked not to reveal any confidential details about their participating patients, nor any patients.

Patient participants were similarly assured that their name would not be recorded on the transcript, nor would it be mentioned in the final report, and that only the researcher and Director of Studies would know of their identity. Patient participants would know that their osteopaths were participating, and were asked not to reveal any confidential details about themselves that they felt uncomfortable sharing.

Any personal identifying features disclosed inadvertently by osteopath or patient participants, who were pseudonymised, were blanked in the transcripts. Potentially identifying features of other osteopaths or of any patients, or of any other members of the public, were also blanked or pseudonymised in the transcripts.

4.10.11. Researcher competence

In order to equip myself to become a competent researcher using the IPA research method, I attended a number of IPA training sessions in London, Derby and Glasgow (see Appendix 2). I also undertook videoed interview training at the University College of Osteopathy, where I received feedback on my technique and was able to reflect on my performance when viewing the recording.

4.10.12. Data security

Only the Director of Studies and I as researcher had access to the consent forms, recordings and transcripts. They were stored securely in a locked filing cabinet in the lockable office of

the researcher. Since completion of the study, they are being stored in a locked filing cabinet in the Research Office at the University College of Osteopathy.

An electronic copy of the recordings and transcripts has only been kept for the duration of the study on a password-protected computer in a locked filing cabinet in the lockable office of the researcher. Once the study has been completed, the electronic copy of the recordings and transcript will be stored on an encrypted external memory device in a locked filing cabinet in the Research Office at the University College of Osteopathy, for six years.

Information that might have allowed individuals to be identified has been blanked or pseudonymised to enhance the anonymity of the transcripts. Transcripts were coded and do not contain the name of the interviewee. The transcripts were sent for checking by the participants and were delivered confidentially by registered mail, with registered return postage included. The transcripts have been analysed by the researcher. The anonymised analysis has been audited by the Director of Studies, Steven Vogel, and overseen by the second supervisor, Dr Geraldine Lee-Treweek, the original third supervisor, Dr Frank Milligan, and the project advisor, Sibyl Grundberg. Quotations from the transcripts in the thesis are brief and anonymised, and this will also be the case in any related publications or presentations.

4.10.13. Ethical approval

Ethical approval was granted by the Research Ethics Committee of the BSO (which has since been renamed as the UCO) on Monday 20th June 2016 (see Appendix 23), and by the University of Bedfordshire's Research Ethics Committee on 13th July 2016 (see Appendix 24).

4.11. Data Collection

4.11.1. Recording equipment

Two Olympus WS-853 audio-recorders were used at each interview (one for back-up in case the other failed). They were carried in a briefcase with a combination numeric lock.

4.11.2. Interview schedules

A copy of the osteopath interview schedule was taken to the interviews with each osteopath participant, and the patient interview schedule was taken to the interviews with each patient participant. I had carried out a practice interview with a student volunteer at the British School of Osteopathy in November 2016 and had memorised the items, so did not need to refer to them during the interviews.

4.11.3. Field notes and reflexive research diary

I made only very brief notes during the interviews in my reflexive research diary, having gained consent from the participants for this at the time of the interviews.

4.12. Location of the Interviews

All of the interviews were conducted in the UK, face-to-face. The place of interview was negotiated individually with each participant. Two of the osteopath participants were

interviewed in their homes; the other two in their clinics. Three of the patient participants were interviewed in their homes; the other was interviewed in the osteopath's clinic.

4.13. Conduct of the Interviews

All participants consented to participate in the interviews, and none withdrew their consent during the interviews. The interviews all had a natural flow following the first one or two questions. I used prompts and follow-up questions, so as to explore the subject matter in as much depth as possible. There was no need to refer to the interview schedules during the interviews, as all the items were addressed during the conversations. All the interviews lasted between 48 minutes and one hour, 18 minutes. On play-back, all the interviews were of good sound quality.

4.14. Transcription of the Interviews

I transcribed the interviews personally, using Microsoft Word, and an Olympus AS-2400 professional transcription kit, comprising a foot-switch (RS28H) and Olympus DSS Player transcription software.

4.15. Transcript Approval

The transcripts were completed between March and July 2017 and were sent to the participants for their approval from May to July 2017. All were approved, some with minor changes, by September 2017.

4.16. Data Analysis Method: Interpretative Phenomenological Analysis

4.16.1. Data analysis process

See Figure 4-1 for an illustration of the data analysis process. I began with a phenomenological reduction, which is a way of saying that I resolved to maintain a phenomenological attitude throughout the data-analysis. The phenomenological attitude is the commitment to remain focussed on the participants' accounts of their lived experience. Associated with the phenomenological reduction is the process of epochē, which involves taking a stance towards one's fore-understandings (i.e. fore-structure) in order to account for their influence (Smith, Flowers and Larkin, 2009, pp. 25-26). I have explained in the Methodology chapter – and later explore in the Discussion chapter – the method I used to account for my fore-structure.

The data was analysed according to phenomenological and hermeneutic principles involving the following stages, for each data-set, serially:

- An initial close reading.
- A re-reading, after which reflective comments were made, identifying the researcher's hermeneutic fore-structure (i.e. my personal perspective, pre-occupations and intuitions).
- A line-by-line descriptive analysis (describing the content of the text).
- A line-by-line linguistic analysis (noting stylistic, rhetorical and grammatical features).

- A conceptual analysis (drawing out meaning, and noting how the participant is meaning-making).
- A hermeneutic analysis in which themes emerged.
- A manual-mental mapping exercise, in which themes were cut up, sorted and clustered.

(Adapted from Smith, Flowers and Larkin, 2009, pp. 79-80; Larkin and Thompson, 2012).

I gave consideration to the phenomenological principles underpinning the stance and attitude of the researcher in an IPA project. As Kidd and Eatough (2017, pp. 261-262) describe, there is a balance to find between empathy and enquiry, and between identifying with the participant's perspective and stepping back from it. What makes the analytical method of IPA multiply phenomenological, however, is its ongoing focus on the way that the participants make sense of their experience. Finding and maintaining a gyroscopic equilibrium was of particular concern in the conduct of the current study, given that the research problem was concerned with sense-making about sense-making, therefore involving a multiple-hermeneutic and ongoing re-orientation within my hermeneutic holosphere.[19] I reflect upon this in the Discussion chapter.

[19] I have used this metaphor in place of the more commonly used, 'hermeneutic circle'. For an explanation of this, please refer to the Methodology chapter.

Figure 4-1 shows a schema of the process of data analysis, with further notes on this process provided at Appendix 3. Figure 4-2 provides an example of the interpretative-analytical notes made on the transcript of a patient participant.

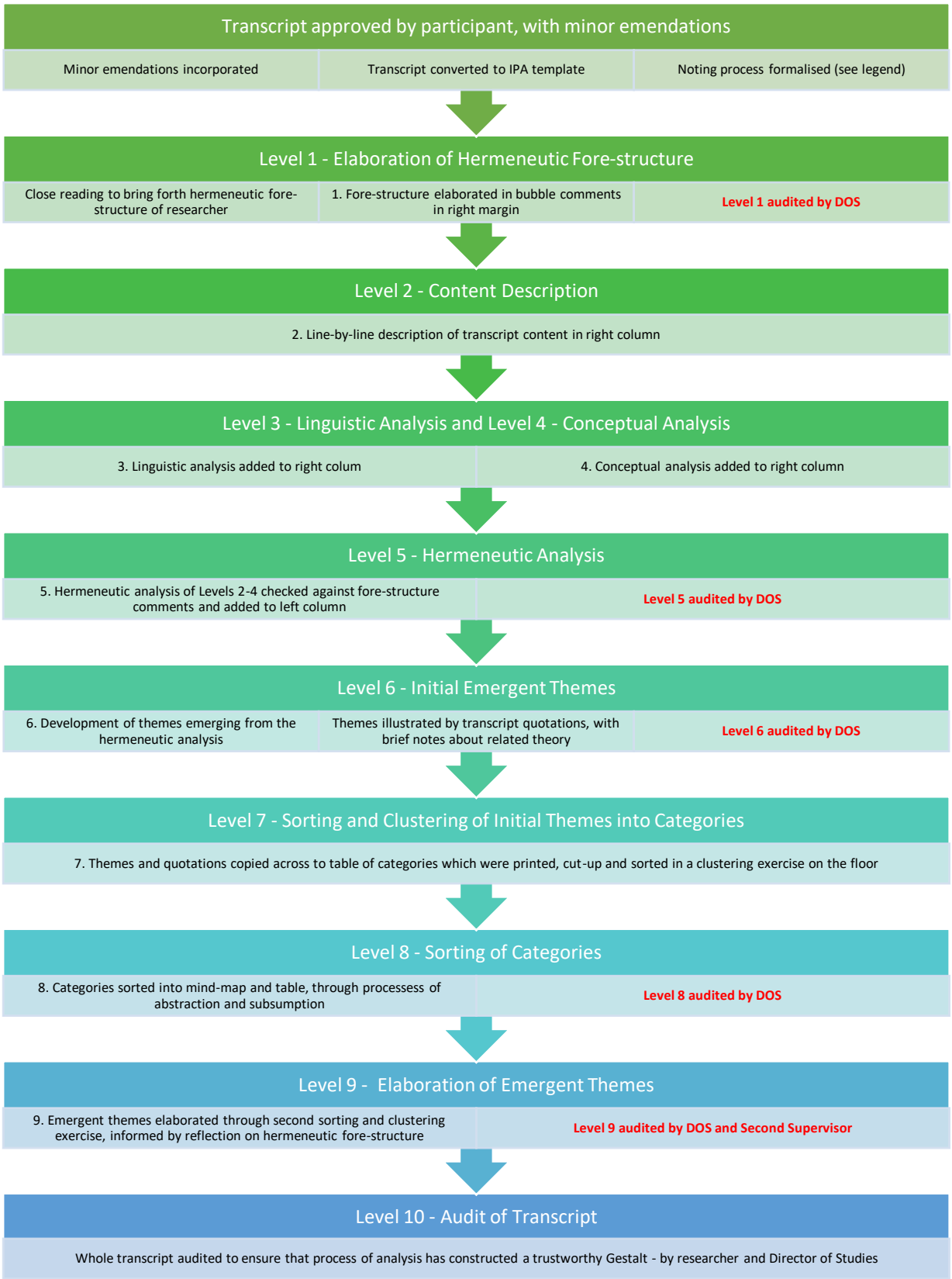

FIGURE 4-1 DATA ANALYSIS PROCESS FLOW CHART

Initial Emergent Theme	Original Transcript	Content, *linguistic,* conceptual analysis	Initial Notes: Hermeneutic Fore-structure
Buried trauma	**Eva: . . . you know, lots of, probably abandonment stuff, and there's a whole lot of stuff that had been, kind of buried . . . but of course the accident . . . you know, there was still *trauma* in there . . .**	She had a sense that there was an element of feeling abandoned that had accompanied the injury. All these years later, the trauma of this accident still felt present. **"probably abandonment stuff, and there's a whole lot of stuff that had been, kind of buried"** – so now there is a sense that the physical injury was encoded along with psychological and emotional features. ***"There was still* trauma *in there"*** *– "trauma" is the word that encapsulates both the physical and the psychological components – they are undifferentiated. "in there" suggests an imprint within the corporeal substrate of Eva's person. The preposition, "in," is consistent with the previous reference to the profundity of the experience of cranial osteopathy. For this trauma to find expression, the osteopath had to search deeply.*	Amanda Banton 28th February 2018 I do believe that shock can be loaded into body tissues by accidents of this nature (i.e. with such velocity and force).
	Mandy: Mm		
Involuntary response to cranial osteopathy **Injuries create patterns that spiral through the body**	**Eva: . . . and having the sessions with [the osteopath] was *incredible* because *everytime* I'd walk out of there – so for a period it was every two weeks – my whole face was twitching after – it was just . . . [laughs] it was really bizarre! And he was, he described it, you know as sort of eighty percent of the energy was still caught in that spiralling pattern of the accident . . .**	The cranial osteopathic treatment made her whole face twitch. The osteopath said that 80% of the energy of the accident was still held within her body. **"my whole face was twitching after – it was just . . . [laughs] it was really bizarre!"** – Eva's body begins to behave in unusual and uncontrollable ways. **"eighty percent of the energy was still caught in that spiralling pattern of the accident"** – Eva has already made reference to patterns that needed to be released. Here, the sense is of cellular retention of the forces of the original injury, imprinted within Eva's corporeal substrate, regenerated throughout her life to this point as her cells renewed themselves, mechanostransduction in action, a trabecular pattern fixed through time. Or, we might be thinking more metaphorically about a holding pattern, a 'plane ready to land' describing a spiralling trail through the skies, awaiting the signal to land safely. Spiralling also presents an image of a vortex as water is sucked into a whirlpool; an infinite vortex spirals through the fluid medium of Eva's body.	Amanda Banton 28th February 2018 Again, I can personally identify with this experience, given my sensitivity to body work (acupuncture, shiatsu, cranial osteopathy), and how "twitchy" my body can be during and after treatment. Amanda Banton 4th March 2018 Siri Hustvedt (2011) "The Shaking Woman" – a psychological discourse will account for this type of autonomic response as somatisation.
	Mandy: Mm!		
Feeling the spiral pattern in the body unwinding	**Eva: . . . and that felt, yeah, it felt really profound that, you know, I mean, how do you come up with eighty percent? But, it was, I could feel it, I could feel it moving . . .**	Eva wasn't sure how it was possible to tell that it was 80% but she was impressed by the sense that the accident had left its mark, and she felt aware of it beginning to shift. **"how do you come up with eighty percent?"** – this phrasing of this question suggests curiosity as much as scepticism. **"But, it was, I could feel it, I could feel it moving"** – she could feel the pattern shifting. She had the embodied experience that correlated with the osteopath's analysis – and she accepted the significance he had imputed to the accident.	Amanda Banton 28th February 2018 An example here of how we must be careful what we say as practitioners, because it is possible to sound inadvertently authoritative and mislead our patients.

FIGURE 4-2 EXAMPLE OF HERMENEUTIC ANALYSIS OF TRANSCRIPT OF PARTICIPANT'S ACCOUNT

4.16.2. Emergence and development of themes

The engagement with the data in generating the themes required a flexible strategy of identifying small units of meaning, clustering them tentatively, identifying cumulative patterns, maintaining reflexivity and having an open-ness to applying theory to the account of the experience, as described by the participant (Larkin and Thompson, 2012). Through this process, as my hermeneutic involvement with the data-set became deeper, themes emerged from the analysis and were recorded in tables and maps (see Table 3, Figure 4-3 and Figure 4-4).

These samples are extracted from the transcript of the first patient participant, Richard[20] (P1). I have selected the example of his depiction of an experience of cranial osteopathic treatment in terms suggestive of a central heating system being fixed. In the paragraph that follows, I give an account of this process of deepening analysis (which I summarise in Figure 4-5), beginning with the relatively descriptive example of the hermeneutic analysis and emergence of themes (Table 3), to the initial theme map (Figure 4-3), to the transformed theme map (Figure 4-4), and finally to Patient Theme 2 – Making sense of the mechanisms of cranial osteopathy.

I began with Richard's words on the audio-recording, which were expressive and emphatic, as he read from the diary he had been keeping of his sessions with his osteopath, Céleste.

[20] This is a pseudonym, as are all other names ascribed to participants.

He described one treatment as “awesome, ranging from pulsating, internal . . . re-circulation” and concluded with a further quotation from his diary: “pulsating, internal re-circulating to infra-red lamp syndrome” (p. 5: 219-222). My initial descriptive analysis and categorisation was to consider these “metaphors for interoception: central heating system” (see Row e) of Table 3). After some further thinking, cutting up the paper theme table, and clustering and sorting the themes, I developed an initial theme map (see Figure 4-3). In the top right-hand corner, I have categorised Richard’s experience as ‘4. Experience of cranial osteopathy’ and particularly ‘4. a) Embodied experience’. This is an abstract category, devoid of Richard’s inflection and containing no trace of the vivacity of his lived experience. Figure 4-4 depicts a more interpretative account of Richard’s lived experience, after I had performed a further ‘phenomenological reduction’. In the top right-hand corner, I capture Theme 3) ‘Vivid awareness of intense bodily sensations’ and particularly 3 b) Fluid, which has two offshoots. One describes the ‘internal cascades [that] flood through the body’, the other the ‘Vivid experience of the workings of the internal circulatory system’.

I give a further account of the ‘internal cascades’ and the ‘workings of the internal circulatory system’ within the Findings chapter, after having conducted the cross-case analysis and having explored the hermeneutic holosphere. The conclusion I reach after deep phenomenological engagement with each of the participants’ accounts is that the metaphors used by the patient participants to describe their embodied experiences are produced to both represent – *and signal the constitution of* – the therapeutic mechanism of action of cranial osteopathy. By this, I mean that the embodied metaphors are not merely descriptive representations, but, importantly, also give an indication of the patients’

understanding of the 'illocutionary force' of the treatment.[21] I discuss this in detail in the Findings chapter.

[21] I have discussed this philosophical and anthropological term in the literature review (Tambiah, 1973/2017).

4.16.3. Example of hermeneutic analysis and emergence of themes: Richard (P1)

TABLE 3 HERMENEUTIC ANALYSIS AND EMERGENCE OF THEMES

Emergent Theme	Quotation	Notes	Fore-structure
a) **Lying supine for assessment and treatment**	"And I lay down and settled: . . . . this is my first experience"		
b) **Cranial osteopathy begins with the feet (instead of the head)**	"this is my first experience, "Hands just touching my feet", and she literally was, umm, socks still on"	Quotation from diary	
c) **"Clonk"**	"suddenly, "*clonk*" . . . . And the noise was extraordinary"		"Audible click" discourse and research
d) **Making sense of the "clonk" – theory 1**	"And I looked at her, head up from pillow, and said, "Was that you?" and she said, as she does in her manner, "Maybe", I, I, I'm thinking, "What has she just done?" and a vertebrae in my back which I didn't know was a problem had realigned . . . "and I said, 'Was that you?' and she said, 'Yes'".	The experience was a corporeal one; the rationalisation a very mental one: "I, I, I'm thinking",	
e) **Metaphors for interoception: central heating system**	"The rest was awesome, ranging from pulsating, internal . . . re-circulation". This is written on the day after . . . umm "pulsating, internal re-circulating to infra-red lamp syndrome", as I call it –"	These vivid terms suggest both embodied (and possibly interoceptive experiences), but could also be thought to suggest the body as an engine or a machine.	

4.16.4. Example of initial theme map: Richard (P1)

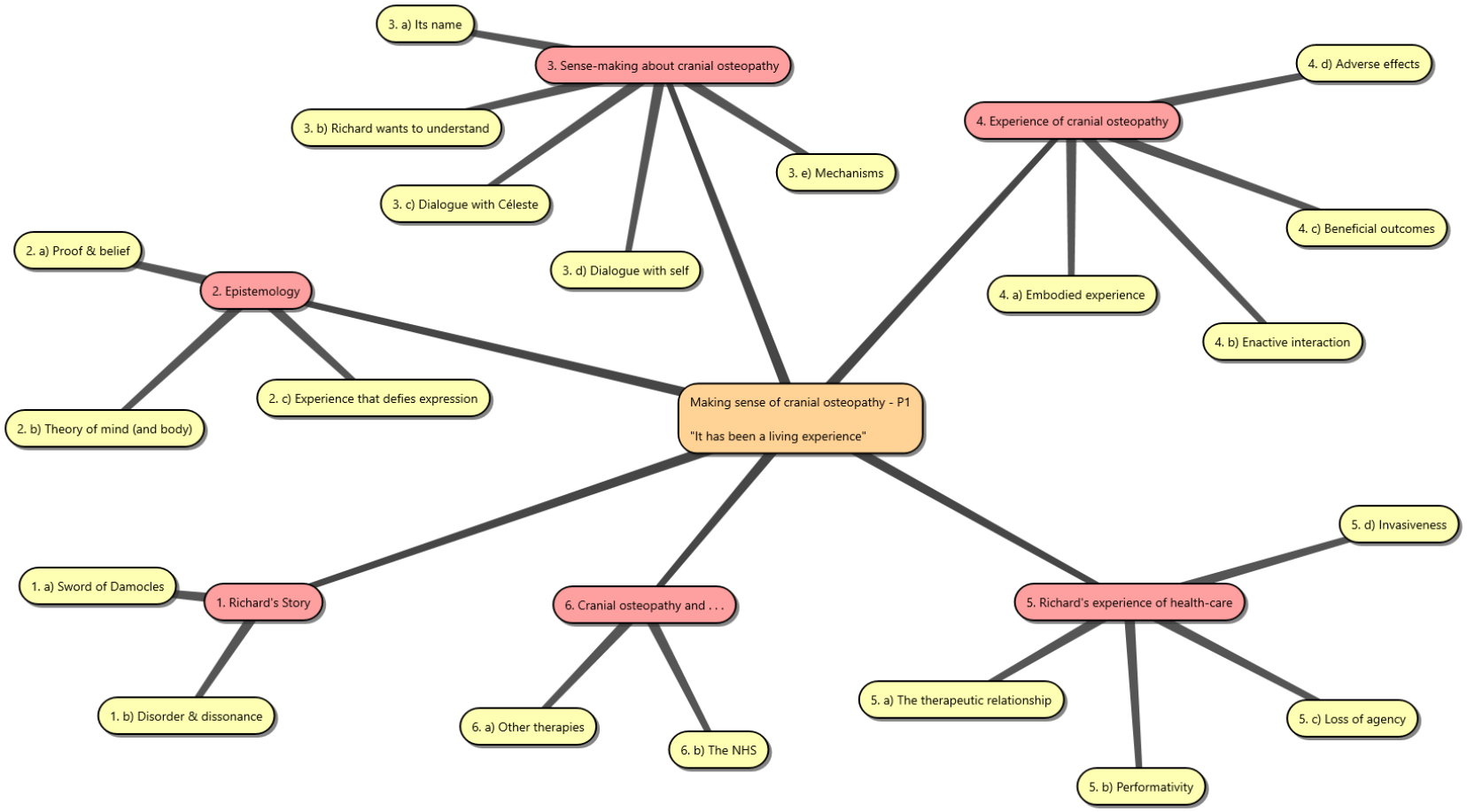

FIGURE 4-3 EXAMPLE OF INITIAL THEME MAP

4.16.5. Example of transformed theme map: Richard (P1)

FIGURE 4-4 EXAMPLE OF TRANSFORMED THEME MAP

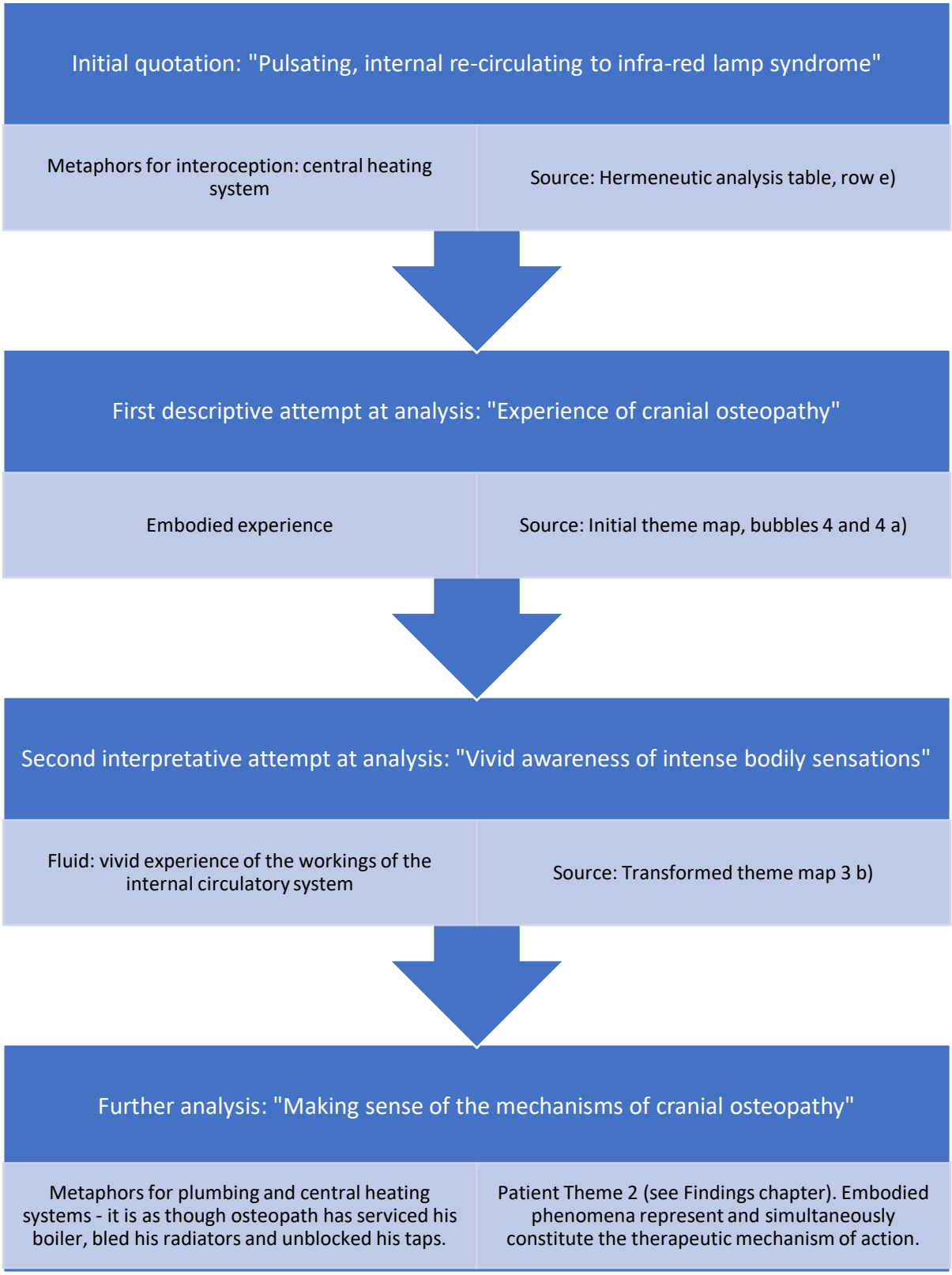

FIGURE 4-5 EXAMPLE OF DEVELOPMENT OF ANALYSIS

4.16.6. Patient and osteopath theme names

The process was repeated for each data-set, and, as insight evolved with each reading of each data-set, I identified subtle interpretative ramifications from the data. I maintained a reflective stance on my expanding field of awareness, noting observations in my reflexive research diary.

I bore in mind that, as van Manen (2017a) advises, the purpose of phenomenological analysis is not to generate themes but to create

> "full-fledged reflective texts that induce the reader into a wondering engagement with certain questions that may be explored through the identification, critical examination, and eloquent elaboration of themes that help the reader recognize the meaningfulness of certain human experiences and events"
>
> van Manen (2017a), p. 777.

This is a lofty ambition, but one that I have aimed towards during the conduct of the study. One example of this is the ongoing reflection I applied to understanding the meaning of the participants, choosing theme names – then revising them, sometimes many times over, as I reflected on the language I had used. In the end, I chose to adopt a criterion of intelligibility that favoured resonance over exactitude; what I mean by this is that I had the intention that the participant would recognise in the language I had chosen a representation of their experience that had truth for them. It is true that, on occasion, I used technical language

(for example ‘aesthetic’ instead of ‘sensory’, in Osteopath Theme 3). This was motivated by the aim to use language that transcended the quotidian inflections of more familiar words.

4.16.7. Cross-case analysis

Following analysis of each individual data-set, I undertook cross-case analyses, to shed further light on the original themes that emerged from the analysis of each individual interview transcript. The cross-case analyses were both dyadic (i.e. each osteopath-patient unit) and grouped (i.e. patient participants and osteopath participants). The aim was to construct thematic patterns of meaning by using a multiple hermeneutic analytical process. The themes that arose from the cross-case analyses were condensations of my understanding of the participants’ meaning-making about experiences that in themselves involved sense-making. The themes were then grouped into super-ordinate themes, distillations of the process of interpretation undertaken with each text serially and with the entire textual *Gestalt* (Smith, Flowers and Larkin, 2009, pp. 79-80).

As will be explained in the Discussion chapter, the methodology did not prove suitable for the aim of exploring the in-depth intra-dyadic meaning-making per patient-osteopath pair.

4.16.8. Super-ordinate themes

Through a selective process of distillation and re-reading the participants transcripts, I settled on three Patient Themes and three Osteopath Themes, and these aligned with each other to form three Super-Ordinate Themes. These are introduced and explained in the Findings chapter. This process involved discussion and debate with my supervisory team, as

they audited the individual participant maps to ensure that the developing Patient and Osteopath Themes represented an appropriate contribution from each participant's account. It also involved a debate about the best language to use. Figure 4-6 demonstrates the process involved in developing an Osteopath Theme, where initial ideas were mapped out and challenged (the definitive version of this theme is to be found in Table 11 in the Findings chapter).

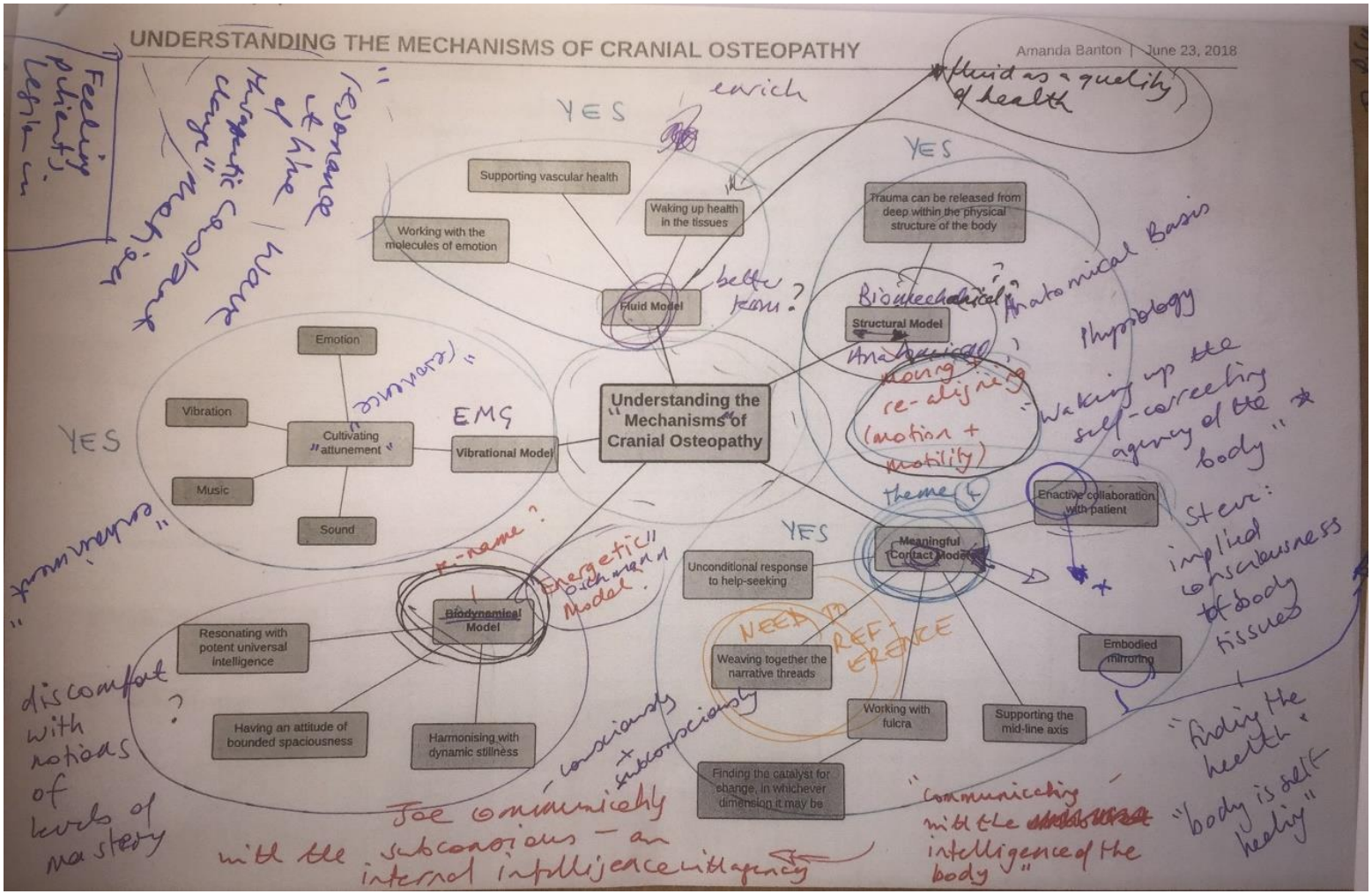

FIGURE 4-6 DEVELOPMENT OF OSTEOPATH THEME 2, MAKING SENSE OF CRANIAL OSTEOPATHY

The process of developing the Super-Ordinate Themes involved setting to one side a Patient Theme and an Osteopath Theme that would have brought additional dimensions to the hermeneutic analysis. The first was a grouping of testimonies by the patients about their life and health stories. If I had been able to incorporate this data, it would have enhanced the idiographic character of the patient participants' account. I decided to exclude it out of respect for the participants' confidentiality (given that they had consented to talk to me about their experience and understanding of cranial osteopathy first and fore-most, rather than about their health histories). The second was an interesting emerging Osteopath Theme that I was loosely categorising, 'professional ontology'. This represented the description by the osteopath participants of their training, apprenticeships and pedagogic work within UK cranial osteopathy. I excluded this data out of respect for the participants' confidentiality, but also – with no little regret – because of the logistical requirements of the current study, and to select the most relevant and coherent material that helped to answer the research question, 'what sense do osteopaths and their patients make of the phenomenon of cranial osteopathy?'

4.17. Quality

The study design and reporting style have been informed by the synthesis of the standards for reporting qualitative research published by O'Brien *et al.* (2014).

Smith (2011) has provided criteria for judging the quality of an IPA paper, and the project has been monitored to ensure that it has met each of these standards:

- It has a clear focus.
- It has strong data.
- It features an interpretative, rather than descriptive, analysis.
- The hermeneutic analysis is supported by rigorous use of extracts from the transcripts, indicating convergence, divergence, representativeness and variability.
- There is a commensurable representation of each participant's lived experience in the thesis.
- Each theme is elaborated in depth, rather than superficially.
- The report is written carefully.

(Adapted from Smith, 2011, Table 10. What makes a good IPA paper, p. 24).

In addition:

- The thesis should be written carefully in such a way as to convey vividness, accuracy, richness and elegance (Polkinghorne, 1983).

The supervisory team have audited the process of data collection, transcription and analysis to ensure that:

- Appropriate data has been collected from appropriately selected participants.
- There is a balance between the particular and the common in the evidence arising from the cross-case analysis.

- The multiple hermeneutic has been applied, with a focus on exploring how participants have made sense of their experience.
- The IPA is contextualised by the existing current literature and theoretical frameworks.
- There has been auditing and credibility-checking.
    - transcripts have been reviewed and approved by the participants.
    - the supervisory team has audited the IPA and the development of themes.
    - the Director of Studies has scrutinised the anonymised raw transcripts to ensure that the selected quotations reflect the breadth of the data.

(Larkin and Thompson, 2012, p. 112).

4.18. Researcher Reflexivity

4.18.1. Fore-structure

I took steps to understand my own epistemic and hermeneutic fore-structures, to own my personal perspectives, and to reflect on my own phenomenological meaning-making throughout the research process. I had regular discussions with my Director of Studies and the Research Group at the University College of Osteopathy, presenting my research ideas at biannual symposia between 2014 and 2017. I underwent an interview, carried out by my Director of Studies using the osteopath interview schedule, a few days prior to beginning my participant interviews; this I recorded, reflected on and used as a source for a hermeneutic analysis at an IPA Data Analysis Course at Derby University in March 2017 (see Appendix 25). I maintained a reflexive diary to record insights into my personal perspectives throughout the project. Extracts are cited as evidence of self-audit to illustrate the trustworthiness of the project and my ability to acknowledge my fore-structure and influences.

4.19. Chapter Summary

This chapter has set out in detail the study design and research methods chosen in order to address the primary research question, 'What sense do osteopaths and their patients make of the phenomenon of cranial osteopathy?' Methodological, logistical, ethical and analytical considerations have been described and justified.

CHAPTER 5: FINDINGS

5.1. Chapter Introduction

In this chapter, I present an introduction to the study participants, then set out the themes that have arisen from my hermeneutic analysis of the transcripts of the semi-structured interviews I conducted with the participants. I have organised the analysis into Super-Ordinate Themes, Patient Themes and Osteopath Themes (see Table 4). The Super-Ordinate Themes represent a coalescence of the shared higher-order meaning of the Patient Themes (see Table 5) and Osteopath Themes (see Table 9).

I demonstrate how my Patient and Osteopath Themes have emerged from an immersive engagement with each participant's experience. I present introductions and summaries to each Theme and maintain a commitment to showing how my engagement with each individual participant has informed my analysis, presenting syntheses of the sources of each Theme in matrical tables. I conclude the chapter with a discursive overview of the Super-Ordinate Themes and an outline of what will follow in the Discussion chapter.

I have ascribed pseudonyms to the participants and cited quotations from their transcriptions with page number and line numbers.

5.2. Introduction to Participants

I set the scene by presenting an idiographic pen-portrait of each pseudonymised participant, in order to provide a Lifeworld context that situates my hermeneutic analysis of their experience of sense-making about cranial osteopathy.

5.3. Patient Participants

5.3.1. Richard

Richard came to cranial osteopathy with symptoms that were side-effects of medical treatment he had been having for a serious illness. He had previously tried other complementary health therapies, such as reflexology and spiritual healing. He found that cranial osteopathic treatment, with Céleste, had a profound effect on him, and it seemed to ease his side-effects. He is curious about the mechanisms of cranial osteopathy, particularly on account of the intensity of his experience of treatment. Richard has had experience of working in a healthcare setting and has a deep curiosity about the relationship between the mind and the body in the experience of health and illness.

5.3.2. Eva

Eva decided to try cranial osteopathy on a recommendation and, being a complementary health practitioner herself, had some pre-conceptions about how it would help her. She found herself drawn to her current cranial osteopath, Sarah, through circumstance and serendipity. She found that cranial osteopathic treatment helped her to relax, breathe and feel more interconnected within her body, and more connected to the ground. She has

some notions about the mechanisms of cranial osteopathy, and these are informed by her personal praxis within the Traditional Chinese Medicine tradition, as a Shiatsu therapist.

5.3.3. Joanna

Joanna turned to cranial osteopathy as a result of an injury and the experience of intense pain. She straddles the worlds of western science and an alternative/holistic philosophy, by dint of her experience of life and work. She found that cranial osteopathic treatment helped with both her psychological and physical symptoms, and she believes this to be via two separate mechanisms. She proposes physiological mechanisms for cranial osteopathy's therapeutic effect that are rooted in her understanding of biomedical science.

5.3.4. Ann

Ann first met her cranial osteopath, Graeme, when seeking help and reassurance with her unsettled baby. The treatment seemed to make a difference, and so she had taken other members of her family to see Graeme over the years. She chose cranial osteopathic treatment after sustaining a traumatic injury, finding that this helped with her recovery, when other approaches had failed. Ann finds the mechanisms of cranial osteopathy mysterious, but wonders if they might belong to a tradition of hands-on healing that is attested in the bible.

5.4. Osteopath Participants

5.4.1. Céleste

After completing her osteopathic training, Céleste was initially sceptical about cranial osteopathy. Her training with the SCCO led to a transformation in her understanding of the application of osteopathic principles and she found that this enriched her practice. She continues to explore and develop her osteopathic praxis through formal education, intra-professional collaboration and reflecting on her clinical experience. She has an active interest in the history and philosophy of science and healthcare.

5.4.2. Sarah

Sarah initially approached cranial osteopathy with scepticism, but became intrigued whilst attending a cranial osteopathy course, and thence began to explore Sutherland's teachings with colleagues. She began to work in a city where patients who were interested in cranial osteopathy seemed to flock to her. She developed her cranial osteopathic skills quickly, and has spent her career getting to know her practice more intimately. She is particularly interested in the art and science of human movement and how trauma impacts upon human health.

5.4.3. Joe

Joe took to cranial osteopathy readily after graduation and has immersed himself in cranial osteopathic education throughout his career. He is interested in the discourse of the philosophy of health in its broadest sense. He has a special interest in the nature of the relationship between the patient and the osteopath, and tries to cultivate an attitude of companionable humility towards his patients.

5.4.4. Graeme

Graeme first encountered cranial osteopathy as an osteopathy undergraduate and was attracted by what he saw as its coherence as a philosophical body of knowledge in the field of holistic healthcare. He has studied it deeply ever since, and has learned from some of the most experienced cranial osteopaths in the world. As a practitioner, Graeme aims to work with what he describes as a quality of mindful stillness, a commitment to being present in the here and now.

5.5. Introduction to Themes Arising from the Hermeneutic Analysis

TABLE 4 SUPER-ORDINATE THEMES, PATIENT THEMES AND OSTEOPATH THEMES

SUPER-ORDINATE THEMES	PATIENT THEMES	OSTEOPATH THEMES
1 Making sense of sense-making	**1** Frameworks for making sense of cranial osteopathy	**1** Cranial osteopaths' ways of knowing
2 Metaphors for mechanisms	**2** Making sense of the mechanisms of cranial osteopathy	**2** Making sense of the mechanisms of cranial osteopathy
3 The meaningful osteopathic relationship	**3** The cranial osteopathic relationship as meaningful rapport	**3** The cranial osteopathic relationship as intersubjective aesthetic engagement

Table 4 provides an overview of the Super-Ordinate Themes that I have generated through an immersive engagement with the accounts of the patient and osteopath participants on the subject of their sense-making about the phenomenon of cranial osteopathy. I first set out my analysis of the Patient Themes (see Table 5), then the Osteopath Themes (see Table 9) and conclude with an analysis of the Super-Ordinate Themes (see Introduction to Super-Ordinate Themes).

5.6. Introduction to Patient Themes

The Patient Themes are organised below in Table 5. They are expressed in three columns, the left-hand containing the higher-order distillation of the sub-themes (which are in the middle column). The sub-themes, in turn, have been drawn from the emergent themes (which are in the right-hand column). The emergent themes are a hermeneutic translation of elements of the patient participant transcripts that I adjudged salient in my close exploration of their accounts. I kept the research question – 'what sense do patients make of the phenomenon of cranial osteopathy?' – in mind as a touchstone at all times. The contribution of each patient participant to the themes is set out in the subsequent Theme tables (Table 6, Table 7, Table 8).

TABLE 5 PATIENT THEMES, SUB-THEMES AND EMERGENT THEMES

PATIENT THEMES	PATIENT SUB-THEMES	PATIENT EMERGENT THEMES
Patient Theme 1 Frameworks for making sense of cranial osteopathy	1.1. Rationalism	a) Domain of orthodox western science and medicine b) Mechanism of cranial osteopathy can be explained by biomedical science
	1.2. Belief	c) Christianity d) Mystery e) New Age epistemology f) Traditional Chinese Medicine
	1.3. Pragmatism	g) Evidence of cranial osteopathy's effect
	1.4. Empiricism	h) Personal experience trumps theory i) A bridge between reason and belief
	1.5. Embodied Consciousness	j) Emotional catharsis k) Deep thought surfaces l) Body-brain dialogue m) Intense awareness of being (in) a body n) Feeling connected to the earth o) Interoceptive signals

Patient Theme 2 Making sense of the mechanisms of cranial osteopathy	2.1. Healing metaphor	a) Spiritual healing b) Biblical healing
	2.2. Psychological metaphor	c) Release of trauma d) Release of emotions e) Release of deep thought
	2.3. Energetic metaphor	f) Energy pathways in the body g) The whole body breathes
	2.4. Attunement metaphor	h) Ritual of care i) Meaningful contact j) Collaborative concordance
	2.5. Physiological metaphors	k) Supporting parasympathetic nervous system function l) Energetic force-field operates on extra-cellular matrix m) Extra-neural cellular signalling
	2.6. Magic metaphor	n) Mechanism is beyond the conscious volitional control of the patient o) Uncanny powers p) Bravura performance defies rational explanation
	2.7. Fluid metaphor	q) Vascular flow improves r) Lymphatic drainage improves s) Neural fluid flow is unimpeded
	2.8. Mechanical metaphor	t) Spontaneous structural re-alignment u) Body changes shape v) Release of strain from body tissues
Patient Theme 3 The cranial osteopathic relationship as meaningful rapport	3.1. Inter-connectedness	a) Interweaving haptic and verbal communication b) Interpersonabilitiy c) Osteopaths project their awareness inside the patient d) Attunement e) Meaningful, warm and gentle touch
	3.2. Trust	f) Asymmetric relationship g) “Gentle boundaries” h) Ritual
	3.3. General practice	i) Continuity of care for whole family j) Osteopaths are like old-school family GPs
	3.4. Counselling	k) Osteopaths lend a listening ear l) Osteopaths support emotional catharsis

5.7. Patient Theme 1: Frameworks for making sense of cranial osteopathy

In this section, I present and illustrate my hermeneutic analysis of the sense-making frameworks elaborated by the patient participants as they describe their understanding of cranial osteopathy and its relationship with other healthcare systems and practices. The source for this analysis is presented in Table 6, where I set out the contribution of my analysis of the account of each patient participant to the generation of the theme.

The patient participants reveal themselves to be sophisticated sense-makers, with an advanced awareness of 'evidence-based' discourse that situates cranial osteopathy in the category of implausible pseudo-science. They describe an oscillation between scepticism, empiricism, pragmatism and a phenomenological openness to experience. They also base their sense-making on some tenets of 'New Age' epistemology and on Traditional Chinese Medicine (TCM). In the end, their living-body experience overcomes some of the external challenges to the plausibility of cranial osteopathy and provides the basis for their understanding for its mechanism (discussed further in the section, Patient Theme 2: Making sense of the mechanisms of cranial osteopathy).

Later, in the Discussion chapter, I argue that, although the patient participants accept and operate within the prevailing dualistic epistemic structure in which thinking is understood to be the work of the mind and sensing the work of the body, their vivid accounts of their intense and novel physical experiences of cranial osteopathy suggest that their sense-making framework has become one that simultaneously collocates the mind in the body and the body in the mind. Table 6 is a matrix of the hermeneutic analysis of each patient

participant's account of their sense-making strategies. The individual patient sub-themes emerge from a cross-case analysis of each individual transcript. The matrix demonstrates the genealogy of each sub-theme, with key-words and phrases providing evidence for the idiographic summaries that follow.

TABLE 6 PATIENT THEME 1: FRAMEWORKS FOR MAKING SENSE OF CRANIAL OSTEOPATHY

	Richard	**Eva**	**Joanna**	**Ann**
INDIVIDUAL PATIENT SUB-THEMES	THEME 2: DISTINCTIVENESS OF CRANIAL OSTEOPATHY THEME 3: VIVID AWARENESS OF INTENSE BODILY SENSATIONS THEME 4: ACTIVE UNDERSTANDING OF BODILY CONSCIOUSNESS THEME 6: SIGNS OF THE TREATMENT'S POTENCY	THEME 1: DIVERSE REALMS OF KNOWING THEME 3: EMBODIED UNDERSTANDING OF CRANIAL OSTEOPATHY	THEME 2: BELIEF AND REASON THEME 4: MANIFOLD AESTHETIC RESPONSE THEME 5: EVIDENCE IS BONE-DEEP	THEME 1: AN ALTERNATIVE PARADIGM THEME 2: MYSTERIOUS MECHANISMS THEME 3: FEELING BETTER AFTER CRANIAL OSTEOPATHY
1.1. Rationalism	X	X	X	X
1.2. Faith	X		X	X
1.3. Pragmatism			X	X
1.4. Empiricism	X	X	X	X
1.5. Embodied Consciousness	X	X	X	X
KEY-WORDS and PHRASES EMERGING FROM HERMENEUTIC ANALYSIS:	Orthodox medicine opposed to alternative health paradigms; cranial osteopath like/unlike spiritual healing, reflexology, yoga, meditation, hypnotism; pathways in the body; emergence of bodily consciousness; internal cascades and tingling; Jesus.	Facts will convince sceptics; naturopathic paradigm; channels of energy; Traditional Chinese Medicine; intuition and embodied understanding; sense is made within the body; New Age epistemology.	Making sense through the conventions of biomedical sciences; faith and uncertainty; empiricism is a bridge between reason and belief; manifold aesthetic response; evidence is bone-deep; uncanny bodily experience; body changes shape.	Taking a different perspective; scepticism disappears with experience; osteopathy as placebo; understanding how it works is not important; subjective and objective experience of getting better; body lengthens from within.

5.7.1. Richard: Frameworks for making sense of cranial osteopathy

Richard is an active hermeneut, trying to make sense of his life on so many levels, stepping back to consider the arc of the last few decades of his life, dwelling within the experience of his illness, reviewing his journal entries to find answers to the questions he has about his therapeutic encounters with Céleste, and constructing metaphors that contain his evolving understanding of his embodied experience of transformation. Throughout our interview, Richard referred to his diary, quoting from it in a way that seemed to support his hermeneutic drive for narrative consistency. He was delighted that he could use the diary as a resource for the study and took pleasure in showing me his neat, minute hand-written notes, and marvelling at how useful they were for the interview:

> "look, I didn't know you were coming (laughs) a year and a half ago, I write these things down – they're very brief – err, it's a summary the next day of what's happened" (p. 13: 546-549).

Richard makes sense in the telling of his story in a digressive manner, inter-relating experiences from his earlier life and from other healthcare contexts, to develop a colourful, textured and finely woven tapestry of his lived experience – that which he calls his "living experience": "Umm, but I think as far as that treatment is concerned, it is, it has been a living experience that continues, umm" (p. 31: 1352-1353).

Richard places his emphasis on living (in the present tense) rather than having lived in the past tense: it is interesting that his language has an action-oriented focus on living – as doing now – which is very immediate.

Richard posits that he knows what he knows through direct encounter with events that he comes up against. His world is one in which metaphysical phenomena present themselves and are accepted – not without critical appraisal – on the basis that he has prehended them with his own senses. This is illustrated by Richard's summation of the effectiveness of Celeste's treatment of his lower limb vascular system following one session, which he reccounts with astonishment and highly expressive language.

> ""PROBABLY THE MOST EXTRAORDINARY SESSION EVER". Capital letters! Oh, I've done a Trump there! Umm, "and, clonk happened at last . . . . Inverted goose-bumps, streaming", literally streaming, I can remember that day, umm . . . when there's no stopping it, you know, it just runs down through your legs. "And my neck, too . . . quite extraordinary"" (p. 24: 1052-1058).

Richard compares himself wryly with Donald Trump, who famously uses capital letters to communicate using Twitter. Richard is knowing about his own use of hyperbole (with the extended implication being that Trump is not). The "clonk" is a felt experience of an intervertebral joint releasing, and the subsequent sensation is that of a gush of fluid travelling down through the legs. Richard uses the term, "literally", in the sense that it feels

exactly so to him. The meaningfulness *and* the salience of this experience "literally" flows through Richard's body.

Richard's indwelling within his physical body is inconstant. There are times when he feels identical with his lived body, but there are times when his body is an object to him. Occasionally, his body parts feel alien to him, and he identifies himself as a mentalising being, trying to make sense of his experience, of his body and of his health through rationalisation, through dialogue with Céleste, and through research. His account suggests an evolving living-body engagement with his ipseity, especially in the sense of his self as having both consciousness *within* – and consciousness *of* – his body.

Of his experience of interoceptive phenomena during a treatment session with Céleste, he carries out an auto-dialogic reflection:

> "Or has it been ticking over in the background and then suddenly the triggers and you're saying to your body, "Hang on, what, what are you up to? What's going on?"" (p. 18: 803-806).

He reveals the sense that this dualistic dialogue is occurring between his reflective brain and his experiencing body:

> "And yet it is so powerful . . . that you suddenly say, "Like, what's that?" And your brain says, "Hang on! What's going on?" Because your conscious level is suddenly experiencing something which is not, umm . . . not, it's not

> acceptable, but it's not, it's something you can't understand, and suddenly your brain says, "Hello! What? And Wow!"" (p. 11: 462-468).

Here Richard conceptualises his brain as a being, perhaps a homunculus, that uses language as a means of coming to terms with novel and disconcerting embodied experiences. He follows this dialogue with a resolute affirmation, that, "it made sense in my head" (p. 12: 495-496), perhaps as a way of shaping meaning out of experiences that make no sense at the time that they stream through his body.

Richard's depiction of his somatic stream of consciousness is urgent, vital and often onomatopoeic. He is vividly aware of internal feelings of muscles tensing, joints clicking, internal paraesthesiae, thermic sensations, and feelings of fluid flowing.

> ""clonk or clunk", umm, "and then my legs start to zing up and down – stays on my feet for some time. Then infra-red lamp" . . . umm . . . something like, it's my writing, "into back and in a few seconds my pelvic area, legs and even arms are alight" (p. 9: 383-387).

The medium of this access is touch – whether hands on the feet, or the head or neck, or on the shoulders, as Céleste seems to perform a ritual of moving to place her hands on or under different parts of his body: "but she would go from my feet always to *there* . . . . Umm, to under my shoulders and then to the back, this new position, there" (p. 13: 558-559).

The intense experiences are precipitated by gentle touch that is not even skin-to-skin:

> "I would get these sort of flowy pins and needles going down my leg, but she was doing it by just touching my feet, and what I couldn't understand initially – well and I still can't – and still can't: she can do it through socks, through clothing, doesn't matter" (p. 10: 419-424).

He feels these events as an incursion of his body, but not necessarily of his person. He is aware of a sense that Céleste has access into and through channels in his body, and he believes that he can trace within himself the feeling of her intentional focus: "I had already learned that she could find pathways in my body" (p. 13: 576-578). This perception of embodied intertwining is explored further, in the analysis of the accounts of the other patient participants, and also in the section on Patient Theme 3, The cranial osteopathic relationship as meaningful rapport.

5.7.2. Eva: Frameworks for making sense of cranial osteopathy

Eva sees naturopathic and orthodox medical paradigms as distinct from each other, but is hopeful that western medicine will become more inclusive of holistic physiological models that view human health as grounded in intra-connectedness. Eva surveys the epistemological divide between western science and older paradigms of knowledge and approves of the increasing understanding and acceptance by the former of embedded wisdom that has survived in cultural practices during the last two millennia. Of western science's perspective on traditional wellbeing practices, she says:

> "it's the laughing, it's all, you know, all the stuff that we know – and of course, some people need to know that there's a physical scientific . . . . . connection – umm – and that's what's great, science is just catching up with . . . . . what old . . . wise . . . systems already have known [chuckling] for 2,000 years!" (p. 16: 692-704).

As a Shiatsu practitioner, Eva has faith that research into naturopathic models of health will eventually win over sceptics, but has no need of scientific proof herself, because she knows what she knows through direct, personal experience.

> ""These are the facts", you know – I think is important and it has use, for me, I don't, I don't need it – I need it more to kind of say to people, "Go and do that, because . . ." (p. 18: 784-787).

Eva's sense-making framework is informed pragmatically by the difference she feels, in herself, following a cranial osteopathic treatment. She describes: "two . . . distinct ways of being . . . the before and the after" (p. 19: 833-834). Eva reports that prior to treatment, she is aching and fragmented; after treatment, she has a sense of presence, calm, embodiment and integration.

> "'cos I know what I feel . . . . That's, that's all the proof I need – it's a hard life – you know, how do I, what do I experience? . . . . . Yeah, that's enough [chuckles]" (p. 18: 795-798).

As a Shiatsu practitioner, Eva has a comparable paradigm ready-to-hand when grappling with the meaning-framework of cranial osteopathy. In fact, she has herself undertaken a weekend course in cranio-sacral therapy, and has incorporated some of its techniques into her own way of working: "we do it in Shiatsu to an extent and it's something that some people develop" (p. 4: 135-136). Eva's comparison of cranial osteopathy with Shiatsu has relevance for her proposition about the mechanism of cranial osteopathy, which I discuss in the section, Patient Theme 2: Making sense of the mechanisms of cranial osteopathy.

Eva gives an account of how cranial osteopathic treatment supports her sense of being in/having a body: "you just feel *all* of you – you feel . . . *embodied*" (p. 6: 265-266). Eva becomes interoceptively attuned to the whole of her body, including its/her interior; for her, the definition of embodiment is "[b]eing aware of . . . . . the inner landscape" (p. 9: 36-387). This evocative image suggests turning the mind's eye, and all the other senses of the

mind inwards, to be able to survey the terrain within oneself. Embodiment entails connectedness to the earth (in both a practical but also a symbolic sense): “remembering that we have feet [chuckles] . . . that they’re connected to the earth” (p. 11: 459-463).

Alongside this heightened sense of being embodied, Eva reports an experience of her whole body breathing, right down to her feet. This type of breathing is slow, full and satiating. It overcomes what she considers to be her adrenergic tendencies. Eva prefaces her description of this bodily breath by inhaling deeply and comes to the idea of contrasting it with the metaphor of ‘fight or flight’, which she distils into the short-hand, “being adrenal” (p. 8: 335). Eva’s experience of her whole body breathing is, for her, the very opposite of a state of sympathetic arousal; instead it is to inhabit a parasympathetic plane of “less anxiety, being slower” (p. 8: 337):

> “to get me to just breathing again, in that . . . other way . . . you know . . . I mean, breathing really, ‘cos I don’t really, but really the whole body breathing” (p. 5: 211-214).

Eva’s lived experience is not just of the health-signifying sensations she perceives during cranial osteopathic treatment, but also of an embodied sense-making of how mechanisms work. For example, she expresses that she knows how cranial osteopathy supports the function of the parasympathetic Vagus nerve (which she understands to contribute to her whole body breathing) because “it makes all sense in *me*”. She says, “so, in a way I don’t

have much understanding of the Vagus nerve, but what I do know just makes, it makes all sense in *me*" (p. 16: 711-713).

Following a discussion with her osteopath, Sarah, about the role of the parasympathetic division of the autonomic nervous system, Eva has found a way of transferring the theory deep within her hermeneutic body and allowing the concept to make sense within her: a semantic-somatic metaphor, in the sense that a metaphor is a structure that carries meaning from one context (her sense-making body) across to another (her cognition). I give a special focus to the concept of the embodied metaphor in the Discussion chapter.

5.7.3. Joanna: Frameworks for making sense of cranial osteopathy

Joanna demonstrates a dexterity with questions of ontology and epistemology. She reveals herself to be essentially a mind-body dualist ("It depends how in my head I am, and how in my body I am" (p. 6: 248-249)) yet one who conceives of the intersection of the sphere of ideas and the sphere of materiality:

> "I'm not *utterly* . . . unconvinced by the idea of transfer of energy . . . by thoughts . . . into brain . . . into electric-electric stimuli . . . . . into, you know, neuronal . . . electric stimuli, into chemical release, into . . . transfer of chemical release, into, you know, that kind of thing . . . I, I, I . . . I don't think we know enough about how little energy is required to make changes in our bodies" (p. 17: 734-747).

Joanna has confidence in reason, and, has left deistic faith behind her: "I definitely think mine is a process of rationalisation, because I'm coming from . . . you know, it's like I'd love to believe in God, but don't" (p. 15: 647-649).

On the other hand, she can now be playful about the everyday uses of belief, such as when she invokes the parking fairies: "I still pray to the parking fairies, and inevitably get parking where I want it!" (p. 20: 857-858). By this adoption of a type of folk superstition, Joanna reveals her epistemological openness to the realm of belief, apparently in dissonance with her work as a scientist. However, she goes on to give a context to her ability to adopt

multiple epistemological perspectives. She explains that, through her study of physiology, she has transformed her way of looking at the world:

> "I think as I've started to explore the way I think about things more, just through studying . . . and believing more in my own ability to think and remember and synthesise, and create, and rationalise, and follow . . . trains . . . . . and my understanding of physiology" (p. 21: 899-907).

Her scientific research seems to have afforded her with the understanding that complex mechanisms are not always readily explicable, and she therefore has an epistemic framework that allows for the possibility that the as-yet-unexplained mechanism of cranial osteopathy may be explained at some future time:

> "I think the way I thought, think about it has changed . . . and I think I, with all of that biology knowledge . . . I think I believe in it more – I just don't know how it works" (p. 21: 911-914).

Setting aside the tension between scientific reason and supersticious belief, Joanna grounds her knowledge about cranial osteopathy in an empirical understanding of her own lived experience: "it's like for me I have empirical evidence! I walk, I walk out of those appointments in a straight line . . . and I don't believe that I could do it myself" (p. 16: 699-701).

Although she uses the phrase, “I can’t tell you how miraculous it was” (p. 4: 146-147), to describe her response to Joe’s treatment, she is using the term ‘miraculous’ to emphasise the extent of her transformation, and only noddingly references the word’s religious overtone.

Joanna finds the epistemological puzzle of cranial osteopathy of such interest that she ruminates on how its practitioners know what they know, and describes a construct of phronesis that enables medical technicians and osteopaths alike to function expertly within their domains, despite the paradigmatic uncertainty inherent within their praxes.

> “somebody somewhere worked out what they were doing before they knew what they were doing . . . and that’s what they’re doing, you know – that’s what all these guys taking X-rays are doing – they’ve no idea what they’re doing! How the physics of the X-rays work – they’re just technicians who are either very, very good at getting pictures, or they’re not . . . and the ones that are really brilliant are the ones that really study it, and really work it out, and think it through, and improve it, and tweak it, and twitch it, and they’re the ones that go on to be the consultants, not the technicians” (p. 21: 927-937).

Joanna describes the fine adjustments one makes, seemingly automatically, when working practically to prehend the physical world that is ready-to-hand, thus she demonstrates

insight into the phenomenological sphere inhabited by the osteopath participants, as I go on to explore in the Discussion chapter.

Joanna's own phenomenological perspective is highlighted in her vivid account of her embodied experience of cranial osteopathic treatment. She describes intense, fine-grained bodily and cathartic experiences during osteopathic treatment – "such a raft of things": physical sensations including itching, fascial tightening, muscular shortening, and a feeling of water coursing within her bones. She riffs on this sense of overwhelming aesthetic rapture that can only be conveyed in its full stream:

> "Physical feelings range from itching, you know, in my lower spine . . . umm . . . to . . . tightening of, of like the internal fascia, like the, the . . . it does feel like it's not muscular . . . . I mean, sometimes it turns into muscular, and it's like a shortening, and it's like a – yeah, well, kind of pull . . . . . umm, but it can also, I've also felt it like it feels like, literally water running down the inside of my, my bones . . . umm . . . what else have I felt? . . . . . Oh, sometimes it just feels like it's sort of – ah! Sorry, I know we're on tape, I can't really describe it, it's, it's like a clicking open; it's like . . . umm . . . . What's it like? . . . . . I can't think of anything that would . . . but it, it, it's like tiny little, like almost 5 mil . . . click and relax, click and relax, click and relax, click and relax, and it just happens, ke-too ke-too ke-too ke-too ke-took . . . . Umm . . . . . Yeah . . . and sometimes it just

> suddenly goes and sometimes it's, I get really sharp little pains and it's like, "Oww!"" (p. 7: 279-299).

Eva's expressive articulation of her inchoate, prenoetic felt experience employs a vibrant stream-of-consciousness flair to convey the vivacity of her living-body experience, the *Gestalt* portraying more than its individual phrases could. Her work in expressing the seemingly ineffable reveals an insight into the phenomenological framework she has constructed to make sense of the phenomenon of cranial osteopathy.

5.7.4. Ann: Frameworks for making sense of cranial osteopathy

The sense Ann makes of cranial osteopathy arises from her narratory account of her children's visits to the osteopath, and both the salience and the meaning that she imputes to cranial osteopathy are grounded within this context. She also has first-hand experience of cranial osteopathy, and reflecting on this experience confirms the conclusions she has come to.

Ann initially consulted an osteopath, despite having concerns about the plausibility of osteopathy, when her first child was unsettled as a baby. "I remember coming down with [my son] and, umm, Graeme, I saw him, and that night he slept through the night – err, because I was a sceptic" (p. 3: 102-104). Here, Ann reveals (and possibly still retains) her initial ambivalence about cranial osteopathy – to her, at that time, an unknown quantity; despite her son sleeping well after his first session with Graeme, Ann concludes this sentence by recalling her initial doubtfulness.

Yet over time, Ann has come to believe that the cranial osteopathic approach provides a different perspective, from within a different paradigm, compared with orthodox medicine: "it's about thinking how – and it's sort of stepping back almost and looking at it from a different point of view" (p. 4: 148-149). Ann's willingness to consider different perspectives is borne of both pragmatism and an experience that orthodox medicine has not addressed some of the concerns she has had about her children's health. She recounts an occasion when Graeme had sensed that one of her children had needed further medical investigations, despite the opposition of her GP:

> "– and the GP, "Oh, there's nothing wrong with him, he's not [ill], he's not this", and so I thought, I said, well, "I'm sorry, but, I have actually taken him to our cranial osteopath . . ". *Soon as I said that! . . . the doors went straight down* and that was the end of that – and he sent me away" (p. 10: 439-448).

Ann experienced the medical profession rejecting the judgement of her osteopath out of hand and interprets this as a clash of paradigms; and possibly a turf war. "[T]he doors went straight down" is a metaphor for the froideur of her GP towards cranial osteopathy. Ann understands that the reason for this hostility is the medical profession's rejection of cranial osteopathy (and its ilk) as placebo-peddling: "it's, you know, the medics will say it's all placebo" (p. 17: 737). She finds this clash of paradigms unsettling, because it makes it difficult to maintain a unified approach to managing the health of her children:

> "I am a sceptic of quite a few things, but I know this does, this is umm, but I also feel quite upset about the fact that the medics don't see it" (p. 18: 797-799).

Ann's evolving openness to cranial osteopathy may be viewed as a pragmatic acceptance that it has worked for her children, despite her doubts about its mechanism; but it should also be considered in the light of her increasing distrust of orthodox medicine – and its failure to consider alternative perspectives on health.

Perhaps as a consequence of her experience with the doubting GP, Ann came to see Graeme as her first port of call whenever her children became poorly and following an

accident of her own. Ann came to know that cranial osteopathy works, because she and her family always looked and felt better after seeing Graeme, and this constituted sufficient proof for her to set aside her scepticism. Ann claims that it is not important for her to understand how cranial osteopathy works: "actually . . . I just accept it" (p. 18: 785) and compares her everyday trust in cranial osteopathy with her reliance on her car:

> "so, it's a bit like the *car*! You get in your *car*, you turn the engine on, and it works – and actually I have *no* interest in knowing how it works, how the petrol gets in – you know, I've *no* interest – all I want to do is sit in it and work" (p. 29: 1301-1305).

Ann's determined avowal of her pragmatic acceptance of cranial osteopathy's effectiveness can be contextualised by her tentative theories about its mechanism, discussed in the section, Patient Theme 2: Making sense of the mechanisms of cranial osteopathy.

Ann's physical experience of cranial osteopathic treatment informs her pragmatism. Unlike the other three patient participants, Ann does not relay a sense of plenisentient absorption in her experience, and she does not give the impression of having perceived a repertoire of interoceptive signals, unlike, particularly, Richard and Joanna. However, she does describe some bodily changes that occur to her during her treatment with Graeme, such as the embodied experience of lengthening inside.

> "It feels . . . . . err . . . I thi-, well . . . I can *feel* things moving inside me – and, partic-, I have quite a stiff back, and I can feel, I can feel

> sometimes I can feel, umm, a release, I feel like umm, you know, so, if you're lying on the bed, you can feel like I'm long-, I'm, I'm – sort of, I've lengthened" (p. 5: 220-225).

She also describes the feeling of breathing differently, having a sense that her diaphragm must have relaxed, although not necessarily noticing how this has happened, or how it felt when it happened:

> "and there's a release and you can just feel, you can just *feel* it, just slightly . . . I don't necessarily – sometimes when my diaphragm is tight, I can, umm . . . I don't necessarily, so I don't necessarily feel the release, but it does feel different – I feel I can *breathe* again" (p. 6: 229-233).

The repeated phrase, "I don't necessarily", appears to function here as a marker of ambiguity: Ann is not sure that she can detect the moment of physiological change, but, like Eva, she experiences the distinction between the 'before' and the 'after' states.

5.8. Summary of Patient Theme 1

In this section, I have considered the hermeneutic strategies adopted by the patient participants, in the context of the multiple epistemological paradigms they inhabit. Each of the patient participants begins with a dualist mind-body ontology that initially limits their epistemological framework to that of positivist empiricism. They work hard to integrate their empirical understanding within a rationalist theoretical framework. In the end, pragmatism – a belief in what works – tends to over-ride their scepticism about the implausibility of the phenomenon of cranial osteopathy.

They tend to appeal to concepts such as holism ('New Age' epistemology) and traditional Chinese medicine to make sense of their embodied experiences, which pose a challenge to their existing belief systems. The patient participants with a spiritual worldview (including Joanna, who has rejected theism) also appeal to the metaphysical as a way of shaping and making sense of their experience.

Each of the patient participants comes to utilise a sense-making paradigm that unites mind with body. I hope to have shown how these embodied experiences – which are described in terms that suggest they are multimodal and pertaining to sensory perceptions from across the spectrum of the senses – have both salience and meaning to the patient participants. I propose that the salience arises from the very fact that experiences of such novelty and intensity occur to them/within them during cranial osteopathic treatment. Their meaning is more fully understood within the context of their explanation of the mechanism of cranial osteopathy. I argue that these experiences are not merely sensory side-effects –

epiphenomena of the cranial osteopathic encounter – but instead an articulation of embodied consciousness, and – more precisely – of a living-body consciousness that is enactivated during cranial osteopathic treatment. Moreover, for each of the patient participants, these intense living-body experiences betoken the operation of the mechanism of cranial osteopathy, as well has causing a transformative effect by virtue of their potent illocutionary force.

These vivid and novel living-body sensations are emphatically bodily experiences and they seem to have several layers of meaning. Firstly, they are felt to be aspects of the mechanism of treatment in that they bring about a desired change in their physical bodies (e.g. a sense of the diaphragm releasing causes the more relaxed and fulfilling style of breathing); secondly, they seem to have an added symbolic significance that represents to them the deeper mechanism of effect of the treatment (e.g. a sense of fluid coursing through the body suggests a release of impediments to the function of the circulatory system; a wave travelling through the body means that the cerebro-spinal fluid is flowing as it ought); thirdly, they have a metaphysical kind of significance that represents an enactivation of their self-healing powers through meaningful contact with their cranial osteopaths.

I now explore how these articulations of living-body consciousness play a role for the patient participants in their sense-making about the mechanisms of cranial osteopathy, via a

process of somatic-semantic[22] hermeneusis, in the following section on Patient Theme 2: Making sense of the mechanisms of cranial osteopathy.

[22] I owe this construction to Schoeller (2016).

5.9. Patient Theme 2: Making sense of the mechanisms of cranial osteopathy

In this section, I present and illustrate my hermeneutic analysis of the sense the patient participants make of the mechanism or mechanisms of cranial osteopathy, that is to say, how they believe it works. The source for this analysis is laid out in Table 9, where I summarise the contribution of my analysis of the account of each patient participant to the generation of the theme.

The patient participants consider a range of models to explain the mechanism of cranial osteopathy, using mechanical and fluid metaphors to make sense of the bodily changes they experience during and following treatment, which have been explored in the preceding section, Patient Theme 1: Frameworks for making sense of cranial osteopathy.

The patient participants also liken cranial osteopathy to spiritual healing, compare it with the psychological process of counselling, and wonder about its underlying energetic effects on their health. They have a sense that attunement with the practitioner has a role to play and, at times, in the absence of plausible explanations, shrugging their shoulders, they wonder whether the effects of cranial osteopathy are conjured through magic.

Later, in the Discussion chapter, I argue that the models developed by the patient participants are 'bricolage constructions'[23] that serve as frameworks with which they make

[23] A concept developed by the anthropologist, Claude Lévi-Strauss, to describe the structure of mythic thought (Johnson, 2012).

sense of their transformative experiences of cranial osteopathic treatment. The bricolage constructions do not *explain* the mechanism of cranial osteopathy, but they serve as metaphors that enable them to come to terms with their experience of the intense, disconcerting and paradigm-shifting phenomenon of cranial osteopathy.

Table 7 is a matrix of the hermeneutic analysis of each patient participant's account of their propositions for the mechanisms of cranial osteopathy. The individual patient sub-themes emerge from a cross-case analysis of each individual transcript. The matrix demonstrates the genealogy of each sub-theme, with key-words and phrases providing evidence for the idiographic summaries that follow.

TABLE 7 PATIENT THEME 2: MAKING SENSE OF THE MECHANISMS OF CRANIAL OSTEOPATHY

	Richard	**Eva**	**Joanna**	**Ann**
INDIVIDUAL PATIENT SUB-THEMES	THEME 5: MAKING SENSE OF MECHANISMS	THEME 2: ENCOUNTERING HEALTHCARE THAT ACTUALLY MADE A DIFFERENCE THEME 3: EMBODIED UNDERSTANDING OF CRANIAL OSTEOPATHY	THEME 6: THEORIZING ABOUT MECHANISMS	THEME 2: MYSTERIOUS MECHANISMS
2.1. Healing metaphor	X			X
2.2. Psychological metaphor		X	X	X
2.3. Energetic metaphor	X	X		
2.4. Attunement metaphor	X	X	X	X
2.5. Physiological metaphor	X	X	X	
2.6. Magic metaphor	X	X	X	X
2.7. Fluid metaphor	X		X	
2.8. Mechanical metaphor	X	X		
KEY-WORDS and PHRASES EMERGING FROM HERMENEUTIC ANALYSIS:	Mechanical, fluid, magic, attunement, pathways in the body.	Making sense of trauma, releasing strain patterns in the body, channels of energy, parasympathetic nervous system support. Mystery/not mystery. Whole body breathing.	Ritual of care, meaningful contact, releasing neural blockages, physiological explanations (mechanotransduction, extra-neural cellular signalling, energetic field operating on extra-cellular matrix), role of the will.	Magic/unlike magic, biblical healing, re-awakening and releasing trauma.

5.9.1. Richard: Making sense of the mechanisms of cranial osteopathy

Richard has a sense of the significance of the embodied phenomena he experiences during cranial osteopathic treatment – they represent and possibly simultaneously constitute the mechanism of action of the therapy in question (whether reflexology, spiritual healing or cranial osteopathy). He attributes the improvement in his symptoms to the undergoing of these intense embodied experiences. He understands that they represent, constitute or cause phenomena that seem to correlate with the improvement in his symptoms, such as joint alignment, gastro-intestinal purging, lymphatic drainage and a sparking to life of the circulatory system.

As an illustration, Richard regularly experiences a clunking sensation in his lower back when he is recumbent, receiving treatment. He conceives of this either as an indirect spinal manipulation caused by Céleste, whose purpose he regards as being to cause a re-alignment of his spine, or as a self-settling of his supine skeleton:

> "I'm thinking, "What has she just done?" and a vertebrae in my back which I didn't know was a problem had realigned . . . "and I said, 'Was that you?' and she said, 'Yes'" (p. 5: 216-219).

> "and the *clonk*, I have to say in my head, umm, I'm thinking I've kind of laid down on something completely flat; perhaps that's something I don't do normally and therefore I'm partially reconfiguring it" (p. 9: 374-377).

Similarly, he theorises that cranial osteopathy is having an effect through its action on his circulatory system, as his "lymphs and circulation and immune system [were] all out of sync" (p. 5: 182-183) and causing the swelling in his lower limbs. He reports that Céleste's treatment caused an "awesome . . . pulsating, internal . . . re-circulation" (p. 5: 219-220) and reinforces the imagery: "pulsating, internal re-circulating to 'infra-red lamp syndrome', as I call it" (p. 5: 221-222). He believes that he must relax and "give in to a certain extent to allow the muscles to co-operate to allow the blood to get in and work – do the work" (p. 12: 502-503). Richard makes sense of what he believes to be effective cranial osteopathic treatment of his circulatory system by employing metaphors that bring to mind plumbing and central heating systems – it is as though Céleste has serviced his boiler, bled his radiators and unblocked his taps; as he reads from his diary,

> ""Ended by touching toes again, like turning on bath taps" and I mean it was just like turning on bath taps inside, umm . . . and that's an experience I'll never forget" (p. 10: 435-437).

And, in one of his most evocative images, Richard ups the rhetorical ante and shifts to a fluviological model when recalling a treatment session when Céleste seemed to be treating his neck:

> "And it literally was like, umm . . . something has cascaded all the way down each side of my spine, and I said to her, "That is just like rivers of blood! What on earth are you doing?"" (p. 13: 567-570).

It may seem extraordinary that Richard would use such a seemingly value-laden phrase to describe a cascading sensation within his body, but it conveys such intensity and a sense of awe that his body could respond in such a vigorous way. For Richard, it felt "literally" – or, in other words, *exactly as if* – his circulatory system had unblocked and his blood was gushing through his body.

Richard also draws on his experience of other forms of alternative therapy to give a context to his understanding of cranial osteopathy. He muses on cranial osteopathy's similarities to and differences from other forms of alternative therapy, an example being his periphrastic account of a recent experience of spiritual healing in which a friend, Alan, had appeared to channel a higher healing force into Richard's body ("And then something just took over, umm, and it was an experience, umm, that is difficult to put into words" (p. 21: 914-916)). Richard edges towards a comparison between the work of Alan, the healer, and that of Céleste:

> "I believe something interfered in that . . . umm . . . situation [i.e. the spiritual healing session] in the same way as, I don't mean 'interfere', umm, sorry, umm . . . 'cos Céleste doesn't interfere . . . but the work that she does, it was in a similar way, to what happened then" (p. 22: 953-957).

After some reflection, Richard was able to conclude that there must be a difference between cranial osteopathy and spiritual healing:

> ""*This* is different . . . umm, and that's one of the reasons why I wanted to feel her [Céleste's] hands and see how much was coming out of her hands to heal, and it doesn't work like that!" (p. 15: 655-658).

Richard interprets the absence of radiating heat in Céleste's palms as confirmation that the mechanism of cranial osteopathy is different from that of spiritual healing, but he is unable to propose a cogent synthesis of how it might work – something he shares with each of the other patient participants.

5.9.2. Eva: Making sense of the mechanisms of cranial osteopathy

Eva has theories about how cranial osteopathy works and believes that it entails the release of traumatic strain patterns in the body. She had experienced an injury as a child, and an osteopath she had seen in the past had explained that, “eighty percent of the energy was still caught in that spiralling pattern of the accident” (p. 3: 95-97).

Eva felt that she required regular cranial osteopathic treatment to help with the retained imprint of trauma: “I ended up going every two weeks to shift some really big patterns” (p. 1: 27-29). Here, Eva conveys the impression of a cellular retention of the forces of the original injury, imprinted within her physical substrate, regenerated throughout her life to this point as her cells renewed themselves, a trabecular pattern fixed through time. Eva’s sense-making is evidently informed by discourse with her original osteopath, and, as will be evident when considering the mechanistic explanations of cranial osteopathy given by Sarah, it has also likely been reinforced by the latter’s interest in the subject of trauma.

Another possible explanation of the mechanism of cranial osteopathy is grounded in Eva’s experience as a Shiatsu practitioner. Eva believes that there are channels of energy that run through the body, of which she has prior theoretical understanding and felt experience: “channels of energy . . . . I feel them as a practitioner . . . umm . . . I mean I, I will visualise them” (p. 6: 257-259).

She knows about these channels of energy on an intellectual level, and she reports that she feels them, haptically, when she works with her hands on her clients. She has a sense that

cranial osteopathy, like Shiatsu, activates these channels of energy – known as meridians in Traditional Chinese Medicine – perhaps permitting the generation of "that *wave*" (p. 5: 208-209; p. 9: 358; 372; 373), the experience of blissful relaxation she has felt during cranial osteopathic treatment, and which she conjures, with the exact emphasis indicated by the italics, on four occasions during our interview.

5.9.3. Joanna: Making sense of the mechanisms of cranial osteopathy

Joanna proposes a range of theories to explain the mechanism of cranial osteopathy. There is the essential ritual of seeking healthcare in itself:

> "so, whether actually just going to Joe's . . . . But what I find interesting is if I do miss it . . . . . even if I feel on fire . . . and just amazing . . . . . I go over that sort of – we manage to stretch it to five weeks, by six weeks, I'm not good" (p. 10: 414-418).

She also recognises that different types of therapy work for different people, and, by implication, the ritual, or some other element, may be more important than the mechanism itself:

> "So I'm aware that different things work for different people . . . because you wouldn't have chiropractic practices that were successful if people didn't have responses from them" (p. 9: 377-384).

She believes that there is an element of catharsis in her own response to cranial osteopathic treatment, as though the meaningful haptic contact of the osteopath draws thought upwards into the light of her conscious understanding from the depths of her body:

> ""But I mean, I, I, so I experience . . . release of emotions; I . . . experience . . . umm, deep thought . . . when someone's just holding you and you've got

> the warmth of their hand on your skin . . . so that alone kind of releases deep thought" (p. 6: 257-265).

Joanna ventures some physiological explanations for the mechanisms of cranial osteopathy that range from the decidedly folk to the sophisticatedly scientific: "releasing blockages" in the neural-fluid course-ways: "it's that feather-light touch which is playing with where the blockages are"; extra-neural cellular signalling, similar to the putative mechanism of Schwann cell signalling in the pancreas; the operation of an energetic field on the extra-cellular matrix; and mechanotransduction acting on connective tissue cells:

> ""the building in the, you know, like actin filaments – they just . . . happen! They're so cool, they just . . . *build* . . . and then they *collapse* . . . and then they *build* and then they *collapse* and then they *build* and . . . I don't *know* how they decide where to build and collapse . . . so why wouldn't it be possible that that process isn't happening in the fascia, if it's triggered or pressured or released, or massaged or manipulated in just the right way" (p. 21: 919-926).

Here Joanna cross-bridges between plausible physiological theory and the domain of embodied instinct to propose an explanatory model that would account for some aspects of her experience of cranial osteopathic treatment, such as the sense that she has of her body changing shape ("my whole body cha- shape changes" (p. 12: 522)). She emphasises that her response to treatment "is a *physical* response" (p. 8: 329-330): an emphatically embodied response to a potentially metaphysical intervention, her living body being the

locus of intersection between the realms of the physical and the metaphysical. The change is actually so profound that it is "bone-deep" (p. 8: 336) – and unfolding within her living body, below the level of mental consciousness. Joanna debates whether her cognitive attention has an impact on the process, and concludes that the physical changes occur whether or not she is paying attention. She therefore concludes that the changes are not driven by any cognitive intention of hers, but are intrinsically embodied:

> "It does feel . . . less consciously-driven . . . and I can give it my attention, or I can leave my attention – and if I'm not focussing on what is happening in my body – some of the time I don't feel it, but some of the time it will intrude into whatever I'm talking about . . . umm . . . . So it's not driven by me thinking about it" (p. 8: 338-344).

Based on her interpretation of the sense of her body changing shape and her understanding of physiology, Joanna concludes that her embodied experiences must be caused by changes to the mechanical properties of her cells, with the cranial osteopath somehow effecting changes at an osseous level, although it should be noted that Joanna seems to employ the phrase, "bone-deep", in both a metaphorical way and also with its physiological connotations, simultaneously.

5.9.4. Ann: Making sense of the mechanisms of cranial osteopathy

Ann has a sense that cranial osteopathy is unlike physiotherapy, and deduces that structural alignment of the body is *not* the mechanism of cranial osteopathy after having had a painful session with a physiotherapist that left her "*so crippled*" (p. 14: 589-590):

> "I remember her saying to me, "Yes, umm, I can see you're, you're not aligned, and you're not", you know, and, so I thought, "Oh, perhaps", – you know, "perhaps I *should* be aligned"" (p. 15: 627-630).

The physiotherapy treatment did not suit Ann, and this led her back to Graeme. Although Ann did not specify the nature of the physiotherapist's treatment, it is likely to have been a more directly mechanical approach than a typical session with Graeme, which Ann described in the words of one of her children:

> ""It's so weird, isn't it? All he does, he just puts your, his hands on your head – and everything feels better!" [Laughs]" (p. 13: 577-579).

The subtle and mysterious experience of the subsequent cranial osteopathic treatment with Graeme led Ann to compare cranial osteopathy with biblical healing.

> "Umm, and so when I went to see Graeme, I remember lying on that couch and, I said to him – anyway he did, you know, and I got up. I said, "You're like Jesus!"" (p. 14: 630-633).

Ann makes the comparison knowingly, but there is certainly the sense that she relates to the experience of characters in the bible who were said to have been healed by the touch of Jesus.

> "I have wondered sometime, whether or not, this is something that someone did. Jesus, you know, when he lay his hands on people, and people got up and walked – to me – that – I mean this is going back to my Sunday school-days, I can't remember the stor- but you know I just remember that story about how he lay his hands – Jesus lay his hands on people and this man with a stick, he got up . . . and then I could just get off the couch – and I *just walked! And I just – I couldn't believe it – it was unbelievable!*" (p. 15: 646-661).

Ann shares with Richard a sense that cranial osteopathy might have some mechanism in common with spiritual or faith healing. The sincerity with which Richard and Ann recount their insights suggest that they might both be open to a spiritual epistemological paradigm, despite their simultaneous appeals towards scepticism and pragmatism.

5.10. Summary of Patient Theme 2

It is not clear to any of the patient participants how cranial osteopathy works. They have come to a pragmatic acceptance that it does, through their own direct personal experience, and they are all (even Ann, despite her avowal of the contrary) curious about its mechanism. None of their discussions with osteopaths, background reading and comparison with other healthcare practices and biomedical science reveals to them an understanding of the mechanism or mechanisms of cranial osteopathy. In the absence of plausible explanations, they generate theories, models and metaphors to explain how it works.

For Richard, cranial osteopathy seems to work through the action of the osteopath projecting her haptic intention into channels in his body to release circulatory system blockages and allowing his fluid systems to flush out and then function again.

For Eva, the mechanism of cranial osteopathy seems to entail the enactivation of the parasympathetic nervous system to improve the flow of the cerebro-spinal fluid which, as it travels through the interconnected nervous system, creates a relaxing wave-form re-alignment of the body, and a sense that she belongs fully within her body.

For Joanna, cranial osteopathy works independently with both her mind and her body to help her to find an accommodation with her persistent pain. She likens her cranial osteopath to a counsellor, but someone who helps her in the physical domain as well. She proposes a range of physiological mechanisms that might explain aspects of cranial

osteopathy's mechanism, such as mechanotransduction and extra-cellular signalling mechanisms.

For Ann, cranial osteopathy has a historical precedent in the type of healing performed by Jesus, as recorded in the New Testament. It makes sense to Ann that, since there are no other convincing or plausible explanations for the mechanism of cranial osteopathy, it might work along the lines of faith healing.

These bricolage explanations are sense-making constructions that stand as metaphors for the mechanism of cranial osteopathy, which defies comprehension and on which their osteopaths shed little light. There is one common insight shared by all the patient participants, and that is the understanding that the therapeutic role of the osteopath is central to the mechanism of cranial osteopathy. I go on to explore this in the following section on Patient Theme 3: The cranial osteopathic relationship as meaningful rapport.

5.11. Patient Theme 3: The cranial osteopathic relationship as meaningful rapport

In this section, I present and illustrate my hermeneutic analysis of the patient participant perspective on the cranial osteopathic therapeutic relationship. The source for this analysis is found in Table 8, where I lay out the contribution of my analysis of the experience of each patient participant in the generation of the theme.

The analysis shows that, while the patient participants clearly respect and admire their osteopaths with a warm regard, the important feature that arises is of the potency of the role played by the relationship, in the enactivation of the therapeutic effect of the treatment. The importance is felt to be two-fold: the very fact that they understand the cranial osteopathic relationship to play a role in their treatment means that it has *symbolic potency* – a kind of illocutionary force; and the process of inter-embodied communication that functions as the medium for the relationship (and which is its hallmark) is one that generates *meaning* for the patient.

Table 8 is a matrix of the hermeneutic analysis of each patient participant's account of their perspective on the cranial osteopathic therapeutic relationship. The individual patient sub-themes emerge from a cross-case analysis of each individual transcript. The matrix demonstrates the genealogy of each sub-theme, with key-words and phrases providing evidence for the idiographic summaries that follow.

Later, in the Discussion chapter, I argue that the symbolic potency and generation of meaning arise within patient-physician relationships across different contexts, and that this

feature may not be unique to cranial osteopathy. However, the intersubjective, tactile-kinaesthetic quality of the rapport that is found in the cranial osteopathic context may be worthy of investigation as a distinct phenomenon.

TABLE 8 PATIENT THEME 3: THE CRANIAL OSTEOPATHIC RELATIONSHIP AS MEANINGFUL RAPPORT

	Richard	**Eva**	**Joanna**	**Ann**
INDIVIDUAL PATIENT SUB-THEMES	THEME 3: VIVID AWARENESS OF INTENSE BODILY SENSATIONS THEME 5: MAKING SENSE OF MECHANISMS	THEME 4: TRUSTING THE PROFESSIONAL	THEME 3: MEANINGFUL THERAPEUTIC RELATIONSHIP	THEME 4: THERAPEUTIC RELATIONSHIP
3.1. Inter connectedness	X	X	X	
3.2. Trust		X	X	X
3.3. General practice	X	X		X
3.4. Counselling			X	
KEY-WORDS and PHRASES EMERGING FROM HERMENEUTIC ANALYSIS:	Osteopath projects focussed attention into his body and enters his pathways – this is disconcerting.	"Gentle boundaries", reliable routine, neutral safe-hold; osteopath "drops into" patient. Osteopath treats family.	Meaningful contact, warm touch, ritual of regular treatment, sanctuary, inter-personability, intersecting verbal and unverbal communication. Counselling.	General practice: osteopath treats whole family; continuity of care; rapport; asymmetric relationship – potential for power imbalance to make patient feel vulnerable.

5.11.1. Richard: The cranial osteopathic relationship as meaningful rapport

During a long-lasting experience of ill-health, Richard has learned to digest and make sense of the medical interventions, across different disciplines, that have kept him as well as he has been. He has also explored alternative healthcare interventions, seeking a more holistic appraisal of his health – and a more meaningful rapport with healthcare-givers. Richard has an understanding that the nature of the relationship with the therapist might be a relevant factor in the change of the course of his illness. This is because he has an understanding that his physiological healing mechanisms can be harnessed by positive intent, which can be recruited through a meaningful interchange with a gifted alternative therapist. After seeing a hypnotist, he came to the realisation "that your mind could actually control bodily mechanisms" (p. 12: 533-534) and, "that mind could be stronger than anything else in a) a healing process or in actually doing damage to your body" (p. 12: 524-526).

Richard comes to realise the extent of the reciprocity of the osteopathic collaboration when he reflects on a treatment session that did not feel effective to him, "it didn't quite . . . didn't quite work . . . and I suddenly realised, you've sometimes gotta be in tune as well as she" (p. 445-446). He conveys an intricate understanding of the interlayering nature of the intersubjective experience he shares with Céleste when, on the other hand, he allows himself to be in tune with her:

> "there are times when we can be sort of having a conversation, and she's not there at all, and I can look at her, 'cos she's on this side, on there, and I suddenly realise, that she is inside as well" (p. 19: 835-839).

This conveys many layers of communication: a) a superficial, phatic, vocalised verbal interchange, b) their physical proximity and the negotiation of the hands-on contact, c) Richard looking at Céleste, d) Richard sensing that Céleste was directing her projected haptic sense within him: a multi-layered, multimodal dialogue. Richard has an understanding that this interwoven method of communication has a role in facilitating the enactivation of the mechanism of cranial osteopathy: through her haptic projection within, Céleste senses and removes the blockage that has been impeding his circulatory system:

> "the way she, umm . . . approached the circulation and what she was doing and how she was, umm, moving through my body . . . and I do mean that – umm . . . . . err . . . 'cos I've learned, umm . . . just from the experience of where she is (chuckles) umm which can be quite disconcerting sometimes, umm, but *that, alone*, it would trigger something there 'cos that's obviously where the blockage is, or was and is still not quite right, umm . . . and I would get these sort of flowy pins and needles going down my leg, but she was doing it by just touching my feet, and what I couldn't understand initially – well and I still can't – and still can't: she can do it through socks, through clothing, doesn't matter" (p. 10: 409-424).

When Richard proposes that it is Céleste "moving through" (p. 10: 411) his body – *"that, alone"* [emphasis in original transcript] (p. 10: 414-415) that would trigger the therapeutic response, he is identifying the meaningful element of the mechanism as what he considers her profound haptic engagement with the depths of his physiology.

5.11.2. Eva: The cranial osteopathic relationship as meaningful rapport

An important part of Eva's appreciation of cranial osteopathy is her trust in the professionalism of her cranial osteopath, Sarah. According to Eva, Sarah is grounded, and works with discretion, "neutrality" (p. 22: 982) and "clear boundaries that are, are *gentle*" (p. 23: 1017). Eva feels at home with Sarah when she takes a step into her clinic, a place which represents a safehold, "safety . . . trusting space" (p. 24: 1059). The "trusting space" is not only the physical clinic, but also the therapeutic realm of her relationship with Sarah, and particularly the atmosphere which Sarah generates about her person, and within her practice: "she's seen me in a state, as well, in the past . . . . . so, but she's very good at just holding it" (p. 22: 973-977).

Eva uses the term, "holding", in its psychotherapeutic sense of holding,[24] and containing as Sarah 'tends' and 'watches over' Eva in her state of distress. Embedded within the expression, "she's very good at just holding it", is a sense of the holding involved in osteopathic touch, which brings an embodied dimension to the meaningful therapeutic rapport.

Eva is curious to know what Sarah believes happens during a cranial osteopathic treatment, but has to ask Sarah directly, since she does not often volunteer insights and explanations: "she won't . . . she won't necessarily share it . . . . Yeah . . . [. . .] Not unless I ask" (p. 17:

[24] The term 'holding' entered psychological terminology after Winnicott (1960) wrote about the holding environment and facilitating maternal role in infant development.

732-738). Eva interprets this withholding as an indication of Sarah's discretion, however, making an unfavourable comparison with "some people who don't, who just go, da-da-da" (p. 23: 1002-1003), that is, fabricate a plausible but superficial answer.

What Eva finds most curious, and can't explain, is the notion of being able to "drop into" oneself, which may reflect her method as a Shiatsu practitioner or a technique she has learned in meditation. She sees a parallel between the idea of 'dropping into' herself and the ability to "drop into" another person – an imaginative act of embodied projection: "the deep mystery which is around dropping into our selves, to be able to drop into someone else, and trust [. . .] what's going on" (p. 25: 1098-1101).

Eva identifies her Shiatsu assessment technique with cranial osteopathic haptic 'listening'. The idea of 'dropping into our selves' suggests a deliberate enactment of indwelling within our embodied selves; 'to drop into someone else' suggests an intersubjective sharing of the experience of being embodied, an ability to identify bodily with another person – a meaningful engagement that requires an intentional physical projection, and not just an empathic imagining of the other's sense of how they are feeling. It is interesting to note that Richard has reported a similar sense of intersubjective entwining (see above), and it is possible to read in the osteopath participants' accounts a context for this extraordinary concept. I go onto explore this intriguing concept of interweaving intersubjectivity in the Discussion chapter, in the sections on embodied empathy and intercorporeity.

5.11.3. Joanna: The cranial osteopathic relationship as meaningful rapport

Joanna believes that a meaningful therapeutic relationship is fundamental to the process of recovery from back pain. As already explained, she finds meaning in the ritual of attending for regular osteopathic 'maintenance' treatment, and in the reassuring predictability of the routine of the treatment she receives: "Joe treats all the same place, pretty much":

> "He holds my feet and he holds sort of behind my ankles, sort of, there [indicating the calves of her legs], I don't know what that part of the anatomy is? . . . He does that at the beginning of every session" (p. 4: 178-188).

She finds her osteopath, Joe, engaging, and his warm touch provides her with a sense of sanctuary – reminiscent of Eva's sense of safety when she is with her osteopath, as described above: "because it's a really nice space to go into when someone's just holding you and you've got the warmth of their hand on your skin" (p. 6: 262-264).

And from this trusting place, Joanna finds that they communicate well at both verbal and unverbal levels:

> "sometimes I'm looking to see what's happening, you know, internally, looking to see what he's working on or where he's working, but sometimes I'll be talking about horse-riding on the moors, and I'll suddenly get a "Oh! God, what are you doing? My calf is twitching!" . . . Umm . . . . . I'm

> always puzzled by how he can maintain the conversations he's having . . . . . . And yet, have very diff-" (pp. 8-9: 358-365).

It is interesting to note that Joanna zones between a close by-stander's perspective and that of a slightly more distant and disembodied persona. This may reflect her dualistic tendency to differentiate between the realms of the mental and the physical, and it also speaks of her trust in her osteopath, Joe.

The significance that Joanna attributes to the mechanism of the patient-osteopath relationship is of greater import than that which can be explained by the safe, warm and supportive therapeutic context that facilitates the manifestation of the healing effects of the treatment, or even of this multi-layered verbal and unverbal style of communication. To Joanna, what is significant about the phenomenon of cranial osteopathic treatment is the condition that the contact between the practitioner and the patient be meaningful, in that it should be both suffused with meaning and make sense to each of them:

> "and maybe it is just that thing where . . . . . your body just needs . . . contact with somebody to heal itself, but I know that massaging, where somebody has just as much as intent to heal as Joe . . . will leave me crippled . . . whereas . . . as with that poor man who gave me . . . you know, chiropracty, and I'd been to see the chiropractic practitioner and nothing happened at all; it was a bit like, "Why are you hitting my ankle?"" (p. 9: 365-373).

Joanna distinguishes between cranial osteopathic treatment, on the one hand, and both massage and the brute “hitting” of the chiropractor, on the other. The factor that imbues her cranial osteopathic treatment with meaning, in comparison with the massage and chiropractic treatments, is the very fact that she finds that it makes sense to her – by virtue of the quality, nature and function of the rapport she has with her osteopath.

5.11.4. Ann: The cranial osteopathic relationship as meaningful rapport

Ann has a long-established sense of trust in Graeme. She does not use this word to describe their relationship, but she implies it and demonstrates it with the years-long acquaintance she and her family have with him. The meaningful nature of their familiarity with one another contributes to the potency of the therapeutic relationship.

> "it's powerful having all that knowledge and history . . . to understand – to have an understanding of not just that person but the background – everything deeper than your psych-, you know, everything, deeper than you, umm, know, this level – umm, and you can only get that, umm, by consistency – and . . . err, and, err, umm, by maintaining that relationship" (p. 26: 1137-1147).

Ann theorises that having a good rapport with a practitioner is integral to the effectiveness of the therapy:

> "the other thing I wonder, actually, is, this is really a conversation – it's whether if you are in tune with the person – it, you have a much better result – whereas if you can't, you know, when you meet someone and you can't, can't quite – there's no reason why, it's not like not getting on, but you just don't, there's no rapport – you can't – I wonder actually – if it's almost like – trying to start a car . . . [and] it's just not connecting – but that could be the same thing – that . . . a sort of, umm, an osteopath and a

> patient – if you haven't got that . . . I wonder whether you would ever say, actually . . . "I'm sorry" [laughs] "but I think it's not working" [laughs]"" (p. 31: 1382-1395).

Ann does note that it is strange having a relationship with a practitioner that is asymmetric – in the sense that "you [i.e. the osteopath] know so much about that person, and also you know so much about *inside* that person" (p. 25: 1073-1074). She can understand how some people may feel a little vulnerable in this sort of asymmetric therapeutic relationship, but it is not a problem for her:

> "I suppose the balance, if you've got weighing scales – you know, yes of course you know, you know, but, you know far more about them [laughs] – and some people – I wonder whether some people find that more vulnerable – but it doesn't bother me" (p. 25: 1091-1096).

Graeme is like an old-school family GP to Ann, and she likens him to Jesus: he is a slightly remote but benign figure imbued with gravitas. Is it possible that she imputes a sacramental dimension in his laying-on of hands? In Ann's case, the therapeutic relationship is one in which the meaningful significance has an element of enactive, ritualistic symbolism, an illocutionary force that accompanies the performance of treatment.

5.12. Summary of Patient Theme 3

Each of the patient participants explores their understanding that the cranial osteopathic relationship plays a vital role in the effectiveness of the therapeutic mechanism. They all find the nature of the therapeutic rapport important in and of itself and they also find it meaningful. I suggest that the patient participants attribute symbolic potency to the significance of the relationship and that they interpret the relationship as meaningful, in the sense that they understand it to be central to the mechanism of cranial osteopathy.

The significant, *symbolic potency* is attested by Richard's, *"that, alone"* (p. 10: 414-415), by Eva's "deep mystery" (p. 25: 1098), by Joanna's "maybe it's just that thing" (p. 9: 366), and Ann's metaphor of the car ignition (p. 30: 1301). The quality of that which is *meaningful* is also referenced by each patient participant, but not always directly. It can be glimpsed with a peripheral glance, arising around the edges of their active sense-making, and in the context of their own Lifeworld.

For Richard, what is meaningful is his interpretation of the "flowy pins and needles" (p. 10: 420) in his legs with the improvement in his circulation and his subsequent testimony, "I had my legs back, I mean, I had my legs back" (p. 16: 705). For Eva, what is meaningful is how the "*wave*" (p. 5: 209) allows her access to a sense of profound relaxation, the very definition of relaxation ("that utter . . . sense of . . . that, that's what relaxed feels like" (p. 6: 244-245)). Despite being a health practitioner herself, she does not access this profound sense of health very often. However, cranial osteopathy allows her access to a sense of health that she believes is our birth-right:

> "To feel that . . . there's something else . . . it's really, it's that deep . . . . . something, I don't know what it is, it's just lovely and that's how you're meant to feel, it's how we're all meant to feel all the time" (p. 6: 247-251).

For Joanna, the sense of what is meaningful emerges within the comparison between the brute "hitting" (p. 9: 372) of chiropractic and the effective, healing "contact" (p. 9: 367) of cranial osteopathy. For Ann, the meaningful dwells within the sacramental symbolism of cranial osteopathy.

Each of the patient participants references a sense of rapport – Richard and Ann directly; Eva and Joanna without using this specific term – as central to the mechanism of cranial osteopathy. The structure of the cranial osteopathic relationship may be given context by the archetypes of therapeutic relationships found in medical systems throughout history and across the world. What is particular to cranial osteopathy (and may be shared to a degree by other healthcare practices involving hands-on bodywork) is the additional inflection of meaning that is communicated via its medium of inter-embodied unverbal communication, a theme I explore in detail within the Discussion chapter.

5.13. Introduction to Osteopath Themes

The Osteopath Themes are organised below in Table 9. They are expressed in three columns, the left-hand containing the higher-order distillation of the sub-themes (which are in the middle column). The sub-themes, in turn, have been drawn from the emergent themes (which are in the right-hand column). The emergent themes are a hermeneutic translation of elements of the osteopath participant transcripts that I adjudged salient in my close exploration of their accounts. I kept the research question – 'what sense do osteopaths make of the phenomenon of cranial osteopathy?' – in mind at all times. The contribution of each osteopath participant to the themes is set out in the subsequent Theme tables (Table 10, Table 11, Table 12).

TABLE 9 OSTEOPATH THEMES, SUB-THEMES AND EMERGENT THEMES

OSTEOPATH THEMES	**OSTEOPATH SUB-THEMES**	**OSTEOPATH EMERGENT THEMES**
Osteopath Theme 1 Cranial osteopaths' ways of knowing	1.1. Experience dissolves scepticism	a) Scepticism in the face of the implausible is understandable b) Empirical evidence overcomes scepticism c) Trust in what works d) Holding the theory lightly e) Not everything can be known f) From black-and-white to grey
	1.2. *Gestalt* perception	g) Intuitive, empathic interpretation h) Balance between right-brain and left-brain perceptivity
	1.3. Open sensorium	i) Proof derives from sensory experience j) Presence k) Peripheral perception
	1.4. Embodied consciousness	l) Intuition as internal dowsing m) Active, bodily hermeneusis of theory
	1.5. Meaning is disclosed	n) Navigating the terrain without a map o) Clarity emerges with lived experience

Osteopath Theme 2 Making sense of the mechanisms of cranial osteopathy	2.1. Intersubjective resonance	a) Cultivating attunement with the patient b) Unconditional response to help-seeking c) Being present with the patient's truth
	2.2. Fluid	d) Working with the molecules of emotion e) Supporting vascular health f) Waking up health in every cell of the tissues
	2.3. Work with the patient's tissues	g) Mechanical stuff h) Getting hold of the structure i) Matching inertia j) Contacting the blood vessels
	2.4. Work with the patient's living body	k) Supporting the mid-line axis l) Mirroring m) Trauma can be released from deep within
	2.5. Centred stillness	n) Harmonising with dynamic stillness o) Finding fulcra in any dimension p) Having an attitude of bounded spaciousness
	2.6. Intelligence	q) Attuning to potent universal intelligence r) Communicating with the self-correcting agency of the patient's living body
Osteopath Theme 3 The cranial osteopathic relationship as intersubjective aesthetic engagement	3.1. Hearing the patient's truth	a) Listening with presence b) Weaving together the narrative threads c) Interpreting embodied experience
	3.2. Haptic hermeneusis	d) Hands are the interface e) Plenisentient receptivity f) Sensing that which is meaningful g) Patient's living body discloses its needs h) *Gestalt* awareness
	3.3. Embodying empathy	i) Synchrony j) Merging of phenomenological fields k) Sharing presence
	3.4. Negotiating trust	l) Meeting the patient on their own terms m) Sharing a steady locus n) Gentle boundaries

5.14. Osteopath Theme 1: Cranial osteopaths' ways of knowing

In this section, I present and illustrate my hermeneutic analysis of the epistemological positions and sense-making strategies that the osteopath participants employ when invited to share their understanding of the phenomenon of cranial osteopathy. The source for this analysis is presented in Table 10, where I set out the contribution of my analysis of the account of each osteopath participant to the generation of the theme.

Each osteopath begins their story with a memory of their initial scepticism when introduced to cranial osteopathy. They all initially understood osteopathy to be a medical practice that could be explained through the empiricist, positivist paradigm of the physical and biomedical sciences. Their experience of cranial osteopathy, however, has caused them to adopt a more pragmatic epistemology. They have been convinced by their direct personal experience that there are complex phenomena that can best be explored (and possibly never explained) through a practical, embodied engagement that involves a wide-open, multimodal aesthetic receptivity and an intuitive appreciation of that which reveals itself, often to the peripheral vision/sensation.

In the practice of cranial osteopathy, the osteopath participants' ways of knowing[25] have come to include an embodied consciousness, a finely attuned and empathic style of

[25] I acknowledge that the phrase, 'ways of knowing', is associated with Carper (1978). I came across this concept in the field of nursing practice after developing this theme name. There are some overlaps between the ideas in this study and those in Carper's framework – particularly in the 'empirical', 'personal' and 'aesthetic' domains (Zander, 2007).

perceptivity, an open sensorium and a phenomenological openness to the disclosure of meaning – in Joe's words, "if the mist clears and the sun starts to come, you know, the, the image might get clearer". In the Discussion chapter, I argue that this epistemological stance could be described as hermeneutic – a state of prenoetic receptivity that permits the being of the patient to communicate with the being of the osteopath in a way that is sense-making, meaning-disclosing and health-unconcealing.[26]

Table 10 is a matrix of the hermeneutic analysis of each osteopath participant's account of their epistemological perspectives. The individual osteopath sub-themes emerge from a cross-case analysis of each individual transcript. The matrix demonstrates the genealogy of each sub-theme, with key-words and phrases providing evidence for the idiographic summaries that follow.

[26] 'Unconcealing' is a phenomenological ontological proposition, introduced in the Methodology chapter, which I go on to explain further in the Discussion chapter.

TABLE 10 OSTEOPATH THEME 1: CRANIAL OSTEOPATHS' WAYS OF KNOWING

	Céleste	**Sarah**	**Joe**	**Graeme**
INDIVIDUAL OSTEOPATH SUB-THEMES	THEME 1: MAKING SENSE OF SENSE-MAKING THEME 3: OPEN-NESS TO THE EXPERIENCE OF UNDERSTANDING	THEME 1: IDEAS ABOUT ONTOLOGY AND EPISTEMOLOGY THEME 3: OPEN-NESS TO THE DISCLOSURE OF MEANING	THEME 2: HOW OSTEOPATHS AND THEIR PATIENTS KNOW WHAT THEY KNOW THEME 3: HAPTIC HERMENEUSIS	THEME 1: WAYS OF KNOWING
1.1. Experience dissolves scepticism	X	X	X	
1.2. *Gestalt* perception	X		X	X
1.3. Open sensorium	X	X	X	
1.4. Embodied consciousness		X	X	X
1.5. Meaning is disclosed		X	X	X
KEY-WORDS and PHRASES EMERGING FROM HERMENEUTIC ANALYSIS:	Receptivity; tacit knowledge; navigating the terrain; phenomena elude naming	Pragmatism; tacit knowledge; presence; sitting in a steady place	Holding the theory lightly; not everything can be known; clarity emerges with experience	Existential sense-making; body resonates to the truth of concepts; a sense of health

5.14.1. Céleste: Cranial osteopaths' ways of knowing

When Céleste began her cranial osteopathic training, she tells me, she accepted guidance from inspiring teachers and colleagues, and learned that there may be different ways of perceiving and different ways of knowing, as she was encouraged, "Trust your hands" (p. 3: 105). Her epistemological framework expanded. She learned that there may be more than one set of ground-rules for understanding the world. At one time she had been very "rational and analytical – very black and white" (p. 1: 23-24), but after immersing herself in cranial osteopathic training, she "realised that things were a bit more grey than [she] had previously, err, thought" (p. 1: 26-27). The reference source for what she knows is no longer confined to the realm of reason, but now includes that of practical engagement: "You know, there's, it's not something that you consciously think about. It's something, and it's something that you . . . umm . . . experience" (p. 5: 220-223).

Céleste began by not knowing what she may be able to perceive through her hands, but accepted that they may be capable of conducting perceptual information that is meaningful in a therapeutic context. Once she made this step towards "trusting her hands", she learned that she had access to a tactile sense that conveys "the *layers* and the *complexities*" (p. 4: 140-141) and "motions and qualities and distinctions between motion and stillness" (p. 17: 729-730). She had no way of interpreting these haptic sensory signals initially, but over time she began to understand that they have significance – they relay something meaningful about the state of health (or dysfunction) of the tissues, systems and integrated-whole of her patients.

> "[Y]ou use your rational and analytical mind, which is generally speaking in that kind of case history taking thing, but, err, then you, you go into those other realms, you know, you go into the, . . . umm . . ., seeing what's coming at you from the edges of the peripheral vision, or the peripheral sensation; you, you look to recognise what it is that's going; and then you try and put yourself in that place, and to actually be that feeling, or that texture, or that sensation; so that you're looking at it in a much, umm . . . broader and deeper and more complete way, and you *know*, you know, you *know*, you *know* that's stuff is getting away from you because you know that there is still stuff that you . . . can feel, but you can't explain, or that you can't even feel, umm, that's kind of beyond your understanding; err . . . but you know little by little, as the years go by, you get – err; you get to be more *fluent*; in that conversation, I suppose; and your vocabulary increases, I guess" (p. 7: 271-289).

Here, in a quotation included in its entirety, Céleste proposes a model of plenisentient embodied knowing that involves a *Gestalt* identification with intentional objects ("to actually *be* that feeling, or that texture, or that sensation"), as well as a phenomenological openness to disclosure ("seeing what's coming at you from the edges of the peripheral vision, or the peripheral sensation"). It involves allowing the intentional object to be appraised holistically – not reductively – and from different perspectives.

It is of note, here, that Céleste's linguistic style, in her extended embodied and spatial metaphor of journeying towards understanding, mirrors that of her content: an urgent, rhythmic appeal to grapple with how to make sense of the liminal ("seeing what's coming at you from the edges") and the tacit ("kind of beyond your understanding"). She describes herself in the second-person perspective travelling from a place of reason to a place where understanding is forged through personal identification with the phenomenon at hand, and the qualities of this "stuff". Céleste's earnest "you know", thrice-repeated, speaks of her frustration and yearning to understand. Her peroratory, "I suppose" and "I guess", supply the anticlimax to this verbal exploration of cranial osteopathic epistemology – indicating that doubt remains.

Although her "vocabulary increases", Céleste finds it very hard to put into words the embodied perceptual experience, conveyed through her hands, that allows her to make sense of her patients' state of health or dysfunction, based on her apperception of the fine-grained, intricately layered textures and patterns that she can read in her patients' living bodies.

> "They say that Eskimos have a thousand words for snow, or something, and it's that sort of level of fine, fine distinction, umm, that you're, that you're picking up, umm, and it is a question of having that whole kind of sensorium open to it" (p. 6: 265-269).

She concludes, ruefully, “It’s, I mean, it’s hard to explain this stuff (chuckles) in words” (p. 5: 216-217). This refrain is echoed by the other osteopath participants, and is a sentiment encountered commonly within the philosophical discourse about evidence-based medicine, often as an appeal against what is perceived as a scientistic agenda pursued by the proponents of orthdox medicine.

5.14.2. Sarah: Cranial osteopaths' ways of knowing

Sarah has moved from a position of scepticism, through one of pragmatism to one of phenomenological openness to the disclosure of meaning.

> "How, how much of one's scepticism is to do with what I don't understand or am unable to feel . . . you know it feels like there are areas that I've been sceptical about that gradually have revealed themselves" (p. 20: 893-897).

She was able to put her scepticism into abeyance as she began to experience, or to witness the experience of, the subtle physiological phenomena of the practice of cranial osteopathy. Her doubt was dissolved within the substrate of her lived experience.

> "I think I don't believe something works until I can feel it. . . . . And when I've felt it, either on myself, you know, either somebody doing it on me, or felt it on somebody else, then . . . . . then it feels like there's not much point in being sceptical [laughs]" (p. 19: 834-838).

Over time, and through the melding of theory and practice, she began to open herself phenomenologically to ever more refined embodied experiences of her patients' health: "I just think through sort of open listening . . . I think we have to try and, I think we have to work . . . to be as open as we can to the unexpected" (p. 12: 534-537). Using this "open listening" attitude, she feels that she can recognise the signature pattern of health when she sits in "a steady place" (p. 22: 968) with a patient, attuning to her, using both subtly receptive/active hands and subtly receptive/active consciousness.

> "I suppose it's the sense of . . . I guess it is a sense of health, isn't it? It's a sense of knowing deeply what health feels like . . . you kind of, you sort of know what, you know what a healthy system is" (p. 14: 595-599).

This kind of knowing – "a sort of *sense* that one's developed" (p. 14: 595) – builds an instinctive ability to recognise patterns and grasp that which is discordant: "it's something about peripheral vision, it, it seems to me that one glimpses things – you kind of glimpse something that doesn't quite feel right" (p. 11: 478-480). An example is afforded by the perception of the quality of osteoporotic bone:

> "it's like – I don't know, a funny sort of hollow . . . umm . . . I don't know, it's like a sort of, it's like a funny sort of vibration . . . it's like a sort of, it's like rather than breathing, the bone's kind of, it's almost like a sort of high-level . . . discomfort-vibration, just, it's like the bone doesn't feel, it doesn't feel right, that doesn't sound very but there's something that doesn't feel – it, it, it's not – it doesn't feel juicy, it feels – umm – a bit high-pitched and irritable – traumat – like a sort of trauma-held" (p. 11: 454-463).

This passage demonstrates the process of constructing thought out of feeling through the production of seemingly catechrestic metaphors that approach, then retreat from, the intentional object at hand (the signature of osteoporotic bone) – the repeated it's-likes, sort-ofs, the run-ups at the object, trying to capture the most apt representation of the phenomenon. Sarah describe acoustic properties – as though palpation were a form of

sonography (“hollow”, “vibration”, “high-pitched”); she refers to qualities that would trigger human distress in whatever domain they appeared (“discomfort”, “doesn’t feel right”, “irritable”, “trauma-held”). What Sarah is describing here is haptic pattern-recognition in action, a mode of practical engagement that, as I go on to propose in the Discussion chapter, may be specific (although probably not unique) to the praxis of cranial osteopathy.

5.14.3. Joe: Cranial osteopaths' ways of knowing

Joe has a light-touch disposition towards the theoretical constructs of cranial osteopathy ("I think it's something I hold quite lightly in my practice" (p. 14: 597-598)) and shrugs that we must accept that not everything can be known: ("I think we can get ourselves tied up in, in knots" (p. 15: 635-636)). He claims he would be a sceptic, only his experience has dissolved his doubts: he knows what he feels; and trusts what he knows:

> "I would be going, "Yeah, yeah, yeah" [chuckles] "Sit round, don't do anything", you know, I know – but I can't do that because I have the, I have the physical sensation that informs, you know, that physical sensation – the sensory experience of the perceived – umm – experience on a daily basis which won't let that part of my mind dominate" (p. 31: 1366-1371).

For Joe, theory in itself is nothing other than a filter through which meaning can be percolated during the active hermeneusis of practical engagement.

> "I start to perceive certain movements in the body, umm, and, may, you know, or lack of movements or inertias, you know qualities of holding . . . or there can be areas which are very active, with, with charge, and then I'm using my anatomy, you know, and, err physiology to translate those into a, into some kind of, to put them together in some kind of context" (pp. 8-9: 355-364).

Joe translates concepts through his embodied understanding, making sense within his body; and in this way, he is a phenomenologist: he paints a picture of meaning emerging from a clearing in the mist, as a shape discloses its qualities from a field of resonant frequencies – understanding as unconcealment:

> "You know, it's a bit . . . it's a bit like sitting in the mist . . . you know, and every now and again the mist clears a little bit, and, you see something, and you might be – a slightly indistinct shape – and you get a sense of it – umm, and then it goes away, you know, and then you could doubt it, because it's gone away [chuckles] – umm – and then if the mist clears and the sun starts to come, you know, the, the image might get clearer – and it often feels a little bit, you know, a little bit like that – you know, certainly in the, in the initial stages" (p. 36: 1594-1603).

As with Céleste, so Joe also employs an extended spatial metaphor in the second-person perspective to convey what it is like to use the phenomenological peripheral glance. His painterly, polysyndetic metaphor has poetic qualities and suggests more ease – and less frustration – with the challenge of explaining how a cranial osteopath knows how he knows. He continues this field-guide to felt-experiencing with a synaesthetic metaphor, now from the first-person perspective, that conveys the process whereby intentional objects arise in his consciousness.

> "I guess it starts off for me, it starts off feeling like a tone . . . you know . . . umm . . . and then, maybe a collection of tones, or noises, you know . . . umm – and then something begins to organise, you know, and, umm, this shape will emerge" (p. 36: 1609-1613).

Joe's description of his experience of apperception and coming to know what is meaningful echoes Heidegger's description of 'a clearing' and will be explored in the Discussion chapter.

5.14.4. Graeme: Cranial osteopaths' ways of knowing

Graeme believes that we can know differently by using our rational mind (the left brain) compared with our imaginative mind (the right brain). He deliberately cultivates a holistic and embodied awareness, by maintaining a right-brain/left-brain balance; and it is through an oscillation between sources that he has been able to move from paradigm to paradigm, crossing thresholds of uncertainty, in order to develop his understanding of osteopathy: "the meaning comes from the – backwards and forwards" (p. 28: 1220-1221).

Graeme attunes his holistic embodied consciousness to the work of learning the professional praxis of cranial osteopathy and finds that he understands what there is to be known both *with* and *within* his body. Concepts and metaphors resonate within his bodily imagination: "It is a resonance physically within – but it's not – it c' – it cannot come without, umm, conceptual deduction that has led to the resonance" (p. 10: 445-447). Theory is important, but only if it can make sense in the body. Sense-making in the body is, for Graeme, a kind of "internal dowsing" (p. 11: 474-475), which he employs to make *Gestalt* judgements that balance left- and the right-brain insights. He describes a lecture that he attended with a renowned cranial osteopath:

> "I didn't hear any of the words – all I could feel was the "voom, voom, voom, voom" and that's where I stayed all the time – for the whole lecture – I didn't care what the words were – I just was getting that understanding that came from a . . . one-on-one body understanding" (p. 28: 1225-1230).

He remembers the effects of a treatment he received from another expert osteopath: "It was *so* profound, and I, ha, I could feel – I could feel every cell in my body doing something [chuckles]" (p. 8: 343-344). As this quotation illustrates, Graeme's teachers have by-passed his intellect and illuminated his understanding through their powerful and meaningful contact with his body. He recounts an example of trying to construct an understanding of the ventricular system[27] within the central nervous system, when the touch of an osteopathic teacher caused him to feel:

> "a *flash* of light go through *all* my ventricles and all my ventricles *lit* up – I could see my own ventricles 3-D – and then he looked straight through me – he knew *exactly* what he was doing" (p. 9: 364-368).

Graeme's striking use of emphasis ensures that this short anecdote is as illuminated as he felt his ventricles to have been: he communicates its salience and meaning urgently. For osteopaths, the cerebrospinal fluid is considered to be "the highest known element that is contained in the human body", according to A.T. Still, the founder of osteopathy (Still, 1986, p. 39).

Graeme recognizes that at the more metaphysical levels, concrete words fail to convey the ephemerality of experiences that may be taking place within dimensions that are beyond

[27] The ventricular system contains (and produces, circulates and drains) the cerebro-spinal fluid within the nervous system.

the reach of even the imagination, and which fail to be captured by all but the most abstract of mathematical modelling. He takes an interest in this level of abstract reasoning ("I listen, I like listening to lectures, I like listening to what people have to say" (p. 9: 418-419), but always comes back to what he knows in his body: "actually, the meaning, you don't need the words" (p. 28: 1220) – "[words] don't *resonate* in me – actions do" (p. 9: 419-420)). This description of bodily understanding – a common theme amongst the osteopath participants, but expressed most emphatically by Graeme – is explored in the Discussion chapter.

5.15. Summary of Osteopath Theme 1

In this section, I have considered the epistemological stances and hermeneutic strategies of the osteopath participants as revealed by their discourse on their experience and understanding of the phenomenon of cranial osteopathy.

Each of the osteopath participants reveal that early scepticism about cranial osteopathy was dissolved in the medium of lived experience, as encountered through a plenisentient and multimodal aesthetic prehension of the phenomenon. A willingness to explore the new "art-science form" (Graeme: p. 3: 101) meant that they had to adjust their world views – with their original "rational" (Céleste: p. 1: 23) positivist preconceptions – to accommodate the "astonishing" (Sarah: p. 7: 280) phenomena that they have encountered in their study and practice of cranial osteopathy.

The osteopath participants' ways of knowing have transformed through their engagement with cranial osteopathy – from positivist to pragmatist, from "black and white" to "more grey" (Céleste: p. 1: 24; 26); from propositional knowledge to a mist-clearing, world-disclosing grasp of the textures, shapes, patterns, stillness and depths that signify the spectrum of health-unhealth. This epistemological shift is the platform for the praxial expertise developed by the osteopath participants and forms the basis for their understanding of the mechanisms of cranial osteopathy (see Osteopath Theme 2: Making sense of the mechanisms of cranial osteopathy) and of the nature of the cranial osteopathic relationship (see Osteopath Theme 3: The cranial osteopathic relationship as intersubjective aesthetic engagement).

5.16. Osteopath Theme 2: Making sense of the mechanisms of cranial osteopathy

In this section, I present and illustrate my hermeneutic analysis of the sense made by the osteopath participants of the mechanisms of cranial osteopathy, that is to say, how they consider it might work. The source for this analysis is presented in Table 11, where I set out the contribution of my analysis of the account of each osteopath participant to the generation of the theme.

The surface explanations are based on both physiological principles (such as the significance for tissue health of the release of the impact of trauma and of the support of the circulatory system) and psychological principles (for example, listening with empathy and helping the patient to weave a narrative that draws the threads of their experience together). These surface explanations are constructed using explicitly metaphorical imagery, in order to suit the contextual conditions of a) talking to a cranial osteopath colleague (i.e. the interviewer, myself) and therefore using a shared argot, b) taking the time to reach deeply within, in order to do justice to a topic that is generally thought to be better understood in the unverbal experience than in the verbal description, and c) making reference to the terms used to explain the putative mechanisms to patients.

These surface explanations can be analysed in the context of both historical and contemporary physiological and psychological theory from the disciplines of both orthodox medicine and osteopathy, as well as from other complementary and alternative healthcare systems. There is a sense from each osteopath participant, however, that these surface explanations do not penetrate deeply into the actual *cause* (in the philosophical sense) of

cranial osteopathic therapeutic effect. They each explore and propose a common theme that has the potential to explain this effect – that of the significance and meaning of the intersubjective cranial osteopathic therapeutic relationship. This nature of this relationship is one of a resonant attunement, featuring embodied empathy, in support of the signature qualities of health and a communication of potent stillness that is taken to both symbolise and enact the therapeutic change which represents the patient's re-orientation towards health.[28] The osteopathic relationship is explored further in Osteopath Theme 3.

Table 11 is a matrix of the hermeneutic analysis of each osteopath participant's account of the sense they make of the mechanisms of cranial osteopathy. The individual osteopath sub-themes emerge from a cross-case analysis of each individual transcript. The matrix demonstrates the genealogy of each sub-theme, with key-words and phrases providing evidence for the idiographic summaries that follow.

[28] The osteopathic relationship is explored further in the discussion of Osteopath Theme 3.

TABLE 11 OSTEOPATH THEME 2: MAKING SENSE OF THE MECHANISMS OF CRANIAL OSTEOPATHY

	Céleste	**Sarah**	**Joe**	**Graeme**
INDIVIDUAL OSTEOPATH SUB-THEMES	THEME 5: ARTICULATING THE MECHANISMS OF CRANIAL OSTEOPATHY	THEME 2: WHAT A CRANIAL OSTEOPATH KNOWS AND HOW SHE COMES TO KNOW IT THEME 4: INTERSUBJECTIVE AESTHETIC ENGAGEMENT	THEME 5: MECHANISMS	THEME 4: MECHANISMS
2.1. Intersubjective resonance	X	X	X	X
2.2. Fluid	X	X	X	X
2.3. Working with the patient's tissues	X	X	X	X
2.4. Work with the patient's living body			X	X
2.5. Centred stillness	X	X		X
2.6. Intelligence			X	X
KEY-WORDS and PHRASES EMERGING FROM HERMENEUTIC ANALYSIS:	Unconditional response to help-seeking; whole-person care; mid-line axis; supporting vascular circulation	Sharing a steady locus; merging of phenomenal fields	Health is spacious; peptides as the molecule of emotion	Dynamic equilibrium; fulcra are found within any dimension; fluid is prime

5.16.1. Céleste: Making sense of the mechanisms of cranial osteopathy

Céleste does not believe that any of Sutherland's models adequately explain how cranial osteopathy might work ("all models are wrong" (p. 3: 133)), even though they are a good starting point in the work of creating the living body of its praxis. She has an understanding that the effective component of the mechanism of therapies such as cranial osteopathy is likely to be peripheral to the causative action of the precise technique selected to address the problem diagnosed. She considers that the patient's help-seeking ("it probably didn't seem to matter what sort of help it was" (p. 10: 410-411)), a sense of existential relief at the unconditional response ("Aah, thank God, help's arrived" (p. 10: 410)), a holistic framing of the symptoms and acknowledgement of the patient's narrative ("people like it when you can, you can put their whole life and all of their symptoms . . . into a sort of meaningful story" (p. 15: 650-653)), might all play an important part in a patient's recovery.

Céleste relates some anecdotes to illustrate her understanding that cranial osteopaths, like other holistic practitioners, support their patients' recovery by developing a collaborative rapport with them. She asks patients to "kind of join in with their own recovery" (p. 14: 624), hinting that the invitation is offered wordlessly, as she talks about a "non-verbal . . . synchronisation with another being" (p. 5: 213-214). She suggests that it is possible to reflect back to a patient a reading of their state of health or dysfunction in a meaningful way that initiates a physiological re-orientation towards healing. She uses the concept of a mirror to suggest both acknowledgement and the collaborative project of re-igniting health. Her intention is to: "really hold up a mirror to her body, or to her *being*, not just her body and, just say, it's okay" (p. 4: 162-163); "my aim was to acknowledge what was there – and

that's the mirror part of it, I suppose" (p. 5: 181). An extension of this idea is the work undertaken with the patient to give her a felt-sense of their midline axis (in cranial osteopathic thinking, this is the notional embryological midline in which the central nervous system develops): "an axis around which she could organise herself" (p. 4: 164-165): "a sense of kind of midline axis, a sense of stillness and stability, some-, somewhere in the central axis" (p. 5: 188-190).

Céleste identifies one particular physiological mechanism that she suggests is of prime importance to osteopathy: that of supporting healing by working to improve body-wide circulatory function. Within cranial osteopathy, this work is undertaken using the haptic and other bodily senses to contact, project within and influence the function of the blood vessels. In this example, Céleste imagines herself communicating with the inner lining of the blood vessels, the endothelium:

> "and if I could have a kind of conversation with the endothelium at that level, umm, and help to kind of physiologically get that system back functioning properly then that would help to . . . umm . . . to bring down the swelling" (p. 9: 361-365).

The dimension within which Céleste contacts the endothelium is one of embodied empathy, in which she can have "a kind of conversation" – a resonant, prehensile aesthetic understanding that she considers may be the factor that enactivates the tissue-healing response.

5.16.2. Sarah: Making sense of the mechanisms of cranial osteopathy

Sarah situates the mechanism of cranial osteopathy within the space that exists within the interplay between the "tangible" (p. 5: 223) facticity of the body (of both patient and practitioner) and "subtle energies" (p. 5: 221) of consciousness (again, of both patient and practitioner): its effect takes place at the intersection between the gross and the subtle, the body and the mind, the external and the internal. She believes that it will one day be explained by the science of quantum coherence:

> "my sort of intuitive feeling about it . . . is, is something like, a, umm . . . . is it to do with coherence? You know, that sense of the body functioning as a whole . . . quantum unit" (p. 6: 258-261).

Sarah has an interest in trauma, both physical and psychological, and how it impacts upon physiological health and the motility of organisms and cells. She believes that this may be an aetiological factor in unhealth that is amenable to cranial osteopathic treatment.

> "I ask myself about trauma, actually . . . and whether or what kind of level of trauma is held in the tissues and . . . whether there's, umm . . . a sort of post-traumatic kind of stage" (pp. 8-9: 359-366).

Release of the imprint of this trauma, which manifests as "strain or, or tension or restriction" (p. 7: 723), is one aspect of the mechanism of cranial osteopathy. The technique that achieves this involves firstly a haptic recognition of the traumatic strain patterns which express themselves as loci of inertia within the tissues, then a "match[ing]" (p. 18: 775) of

the inertial tone through the use of a fulcrum. This "matching" is an expression of both manual and mental intentionality: "we use our mind a lot . . . very, very subtle pressures, but mainly consciousness, really" (p. 7: 288-289). This terminology would be recognised by body-workers other than cranial osteopaths, but interestingly they have psychological overtones too. Sarah talks about how she can "find a kind of resolution of those strain patterns" (p. 17: 724-725) – as though this were a matter for negotiation – or even arbitration, again extending the psychological metaphor.

For Sarah, the mechanism of osteopathic treatment has to do with facilitating tissue respiration ("the fluid field" (p. 16: 699)), in order to clear "inflammatory changes" (p. 16: 700-701) and "support the, the motility" (p. 16: 701-702) of the cells. Simultaneously, there is a whole-person response: a rhythmic soothing and calming of distress: "hopefully the, the, the motility will, umm, will, will enable it to, to, umm, to, to breathe and soothe and, and calm down" (p. 16: 702-704). The restoration of the breath has both a psycho-physiological significance and, contained within this significance, a primal existential meaning.

Sarah knows that and how she perceives these experiences, both through her hands and through a wider open sensorium, but she finds it hard to articulate what this entails. She describes:

> "looking to err . . . support the health, her health in her body, which is, which is *manifested* as, as *motion* and, and a kind of subtle – subtle but

> powerful – tissue motility and, in a sense a kind of, in a sense a kind of – breath through the tissues" (pp. 16-17: 714-718).

She can say that certain factors are at play: ongoing practice, receptive openness, listening and observing from a steady locus as well as an embodied awareness of vibratory physiological signals: the operation of an inter-embodied contact to support a less tangible sense of that-which-is-health – "a something" (p. 13: 549-540) that is glimpsed peripherally through a clearing of the perception, amongst layers of complexity. This is a metaphor that is shared with Céleste's interpretation of "non-verbal . . . synchronisation with another being" (p. 5: 213-214), and, as I will show, with the experience of both Joe and Graeme too.

5.16.3. Joe: Making sense of the mechanisms of cranial osteopathy

Joe's appreciation of osteopathy owes much to the biodynamic paradigm,[29] and he is able to discourse with apparent ease on the subject of the relationship of the health of the individual with the supra-conscious Intelligence that suffuses all human life. He uses the metaphors of divinity and collective consciousness to convey this intelligence that orchestrates our health and which is simultaneously both external to us as well as continuous with the physiology of each individual one of us. Joe identifies the interface between the "internal physician" (p. 5: 192) (i.e. each individual's physiology) and "the potency of the tide"(p. 5: 196) (i.e. the greater Intelligence) as a tangent between the operation of innate health within the individual and the effect of the universal tide which controls the biorhythms of all animate life.

For Joe, it is the role of the osteopath to act as a conduit between the greater Intelligence ("some kind of intelligence which, which is brought to us . . . in order to enable us to change" (p. 5: 208-209)) and the intelligence of the patient's physiology ("that we're infused in, if you like" (p. 5: 214)). This begins when he sits and 'listens' to his patient's body: "what I'm really waiting for is for their body to wake up and start talking to me – or – to decide that it's safe enough" (p. 8: 349-351).

[29] A specialised form of cranial osteopathy that is oriented towards working with 'a higher wisdom' and the 'Soul of Osteopathy' (Jealous, no date).

For Joe, the mechanism relies on the agency of health within the deeper body of the patient to begin to express itself:

> ""I'm looking for qualities within the, you know, within the tissues as much as, as anything, and, and then how those qualities start to unfold and reveal, you know, what the intention of the body is in reorganising".

This idea of the body's internal agency or intelligence, operating on a plane that is somehow out of sight of the patient, may be that which participates in the unconcealment of health – something I explore in the Discussion chapter.

This proposed therapeutic mechanism of the reorganising body involves an expansion of the cellular matrices of the body so that the circulatory systems can irrigate and nourish the tissues adequately. Joe seeks:

> "a quality that's more spacious . . . and where there's an easier sense of flow . . . and where there's more of a sense of breathing . . . in the structures you're working with, and preferably through the whole body, yeah" (p. 37: 1619-1628).

Joe also provides other models for the mechanism of cranial osteopathy. One is a vibrational model in which he detects the tone of a "mass of peptides vibrating at a similar frequency" (p. 10: 440-441) and uses his embodied intentionality to harmonise the tone. Another is a more biomechanical model: "for some people it is just a matter of getting hold of the

structure, trying to meet it where it is" (p. 6: 264-265). This latter has echoes of the concept of both Sarah and Graeme that structural trauma must be addressed in order for healing to ensue – a thought that may arise from one of the founding principles of osteopathy that is used to rationalise and justify the use of manual physical therapy to support recovery from the effects of old injuries (McKone, 2001, pp. 81-85).

As Céleste has done, Joe has moved on from the Sutherland explanatory model of the mechanism of cranial osteopathy, and – in common with Graeme – uses the metaphysical metaphor of Intelligence to make sense of the therapeutic process at the heart of his practice. For Joe, cranial osteopathy entails the bringing together of the potency of each individual's intelligent physiology with that of 'the tide' (i.e. the greater Intelligence). This metaphor stands for the harmonisation of the individual to their holosphere (i.e. their Lifeworld) through a process of attunement between the individual and the orchestration of the forces that control the biorhythms of all animate life.

5.16.4. Graeme: Making sense of the mechanisms of cranial osteopathy

Graeme sketches out his understanding of the mechanism of cranial osteopathy, using a series of interlinked themes. The osteopath cultivates presence (a commitment to the here and now: "not just floating off – but being present" (p. 7: 307-308)) and attunes to a universal source of dynamic stillness so that he can locate a fulcrum within some aspect of his patient's being:

> "and when you sit at the sweet spot, then you can allow yourself to go into stillness, and the patient goes into stillness, and then that, that other change, that we can't really explain, we make stabs at – that's when that other change takes place" (p. 7: 286-290).

The "other change" is the important and meaningful change that represents the patient's re-orientation towards health. The fulcrum is a mechanical or a metaphorical point around which this change occurs. The fulcrum may exist within the four dimensions which we, as humans, grasp easily; or it may exist in other less conceivable dimensions:

> "the fulcrum for the problem in this given patient – is not in the dimensions that I, the, the superficial dimensions that we're currently looking at – but it might be another dimension which I have no knowledge of" (p. 16: 689-692).

Graeme goes on to explain the "other change" as the operative force of potent intelligence to animate and heal whichever aspects of the patient's being have been struggling to

express health. This requires that "[y]ou keep on holding the stillness – with no preconception"(p. 16: 692-693) – a Zen-like attitude of dynamic balance. The stillness must not be "lock[ed] . . . down" (p. 21: 899); the potency is comparable to the centrifugal axis at the eye of the hurricane: "an active stillness" that resists fixity (p. 21: 906-907).

For Graeme, health is associated with fluidity and buoyancy; unhealth with density and fixity. The mechanism of cranial osteopathy involves working with the fluid of the patient's body:

> "Fluid is all-important, because if you haven't got . . . fluid – intra- and extra-cellular – then the potency cannot work through the fluid, and you cannot have health – so, fluid is prime" (p. 15: 650-653).

The mechanism of cranial osteopathy also involves the dispersal of the physical imprint of trauma or illness that is held by the cellular memory of the patient's tissues, and sometimes this must be accomplished before the work can begin to restore the fluid health:

> "*but* you've got to have done all this mechanical stuff to get here for the stillness to then be able to change – you can't just sit in the stillness, 'cos what about all that mechanical stuff that's not being dealt with?" (p. 27: 1192-1196).

As with the other osteopath participants, Graeme has the sense that trauma and illness create a lasting impact within the substrate of the patient's tissues and that it is an

important aspect of the mechanism of cranial osteopathy that the pattern of trauma be assessed, acknowledged and released in order for tissue healing to occur, so that health can be expressed.

5.17. Summary of Osteopath Theme 2

Each of the osteopath participants suggests physiological and psychological mechanisms for the therapeutic effect of cranial osteopathy. Céleste describes improving the function of the circulatory system of her patient, and also proposes the non-specific mechanism of help-seeking by patients as a contributor to the action of cranial osteopathy. Sarah, Joe and Graeme all propose the release of the physical imprint of trauma as aspects of the mechanism. For Sarah, Joe and Graeme, sitting in stillness and providing patients with a sense of safety is a contributive aspect of the therapeutic mechanism of cranial osteopathy. Despite the care of the participants to convey the complexity of the process of cranial osteopathy, these explanations are relatively simple, and do not plumb the depths of the lived experience of the way it seems to them that cranial osteopathy works.

With careful consideration of the difficulty of the challenge, the osteopath participants also venture into the realm of the ineffable – and possibly of the metaphysical – in attempting to describe the mechanism of cranial osteopathy at a deeper level. What they convey could be considered to represent that which is anthropologically symbolic about other healthcare practices – and therefore potentially not specific to cranial osteopathy itself. They use metaphor to describe what I propose may be a meta-metaphorical process – one in which meaning is transferred to the patient as the osteopaths gain an understanding of the signature of health by making sense of their perception of the unhealth of their patients.

The metaphors include:

- Céleste's bodily projection of a felt sense of the patient's own midline axis by using a metaphorical mirror.
- Sarah's sitting and finding a steady place in herself and identifying it with a matching steady place in her patient.
- Joe's attunement between the patient's "internal physician" (p. 5: 192) and the greater Intelligence of the sphere of all animate life.
- Graeme's work to help his patient experience the universal dynamic stillness whose locus is the "eye of the hurricane" (p. 21: 907).

Underlying this metaphorical work is the sense that what is most operative in the mechanism of cranial osteopathy is the "non-verbal . . . synchronisation with another being" (Céleste: p. 5: 213-214). I explore this further in the next section (Osteopath Theme 3: The cranial osteopathic relationship as intersubjective aesthetic engagement) and I go on to argue in the Discussion chapter that the mechanism of intersubjective patient-osteopath communion that is described by all osteopath participants may itself be the factor that both *creates* the condition for the therapeutic effect of cranial osteopathy and also *constitutes* the most significant aspect of its mechanism – that of the unverbal, meaningful coming together of the help-seeker and the help-giver in the hermeneutic project of making sense of the patient's distress or dysfunction.

5.18. Osteopath Theme 3: The cranial osteopathic relationship as intersubjective aesthetic engagement

In this section, I present my hermeneutic analysis of the osteopath participants' sense-making about the intersubjective aesthetic engagement[30] they have with their patients. This relationship can be said to be 'intersubjective' in the sense of Gadamer's metaphor of the merging of horizons of understanding (Svenaeus, 2000a, 2000b, 2003); it can be said to be 'aesthetic' owing to its multimodal, plenisentient medium of communication; and it can be called an 'engagement' with respect to the sense of pledgefulness that the word carries. The source for this analysis is presented in Table 12, where I set out the contribution of my analysis of the account of each osteopath participant to the generation of the theme.

In the Discussion chapter, I propose that the intersubjective aesthetic engagement between the osteopath and the patient is a hermeneutic endeavour: a means of sense-making in which the two participants come to a prenoetic understanding of what ails the patient and what a sense of restored health might feel like. I also argue that the intersubjective aesthetic engagement can be thought of as both a medium of sense-making and the moment of symbolic enactivation of therapeutic change.

Table 12 is a matrix of the hermeneutic analysis of each osteopath participant's account of their understanding of the cranial osteopathic therapeutic relationship. The individual

[30] I wish to thank the late Prof. Stephen Tyreman for the conversations he and I had in the spring and summer of 2018 trying to coin the most apt phrase for this experience.

osteopath sub-themes emerge from a cross-case analysis of each individual transcript. The matrix demonstrates the genealogy of each sub-theme, with key-words and phrases providing evidence for the idiographic summaries that follow.

TABLE 12 OSTEOPATH THEME 3: THE CRANIAL OSTEOPATHIC RELATIONSHIP AS INTERSUBJECTIVE AESTHETIC ENGAGEMENT

	Céleste	**Sarah**	**Joe**	**Graeme**
INDIVIDUAL OSTEOPATH SUB-THEMES	THEME 4: INTERSUBJECTIVE AESTHETIC ENGAGEMENT THEME 5: ARTICULATING THE MECHANISMS OF CRANIAL OSTEOPATHY	THEME 4: INTERSUBJECTIVE AESTHETIC ENGAGEMENT	THEME 2: HOW OSTEOPATHS AND THEIR PATIENTS KNOW WHAT THEY KNOW THEME 3: HAPTIC HERMENEUSIS THEME 4: THE MEANINGFUL THERAPEUTIC RELATIONSHIP	THEME 4: COMMUNICATING WITH PATIENTS THEME 5: MECHANISMS
3.1. Hearing the patient's truth	X	X	X	X
3.2. Haptic hermeneusis	X	X	X	X
3.3. Embodying empathy	X	X	X	X
3.4. Negotiating trust		X	X	X
KEY-WORDS and PHRASES EMERGING FROM HERMENEUTIC ANALYSIS:	Holding a mirror to the patient's being; wariness of trauma resurfacing; explaining mechanisms is burdensome	Sharing a steady locus; merging of phenomenal fields	The therapeutic relationship is paramount; the understanding of the patient must go deep; communication is at a physical and metaphysical level; patients understand myriad metaphors	Sensitivity to intersubjective tangent; constructing an appropriate language; reassuring explanation of procedure

5.18.1. Céleste: The cranial osteopathic relationship as intersubjective aesthetic engagement

Céleste learns through experience that she can help her patients by using her haptic perceptual apparatus to understand their state of health or dysfunction and by acknowledging, tacitly, what she finds. She does this non-verbally, using an intersubjective method of communication that involves a reciprocal embodied resonance: an attunement – a synchronisation. As we have already seen, Céleste considers this mode of engagement – a sort of "non-verbal . . . synchronisation with another being" (p. 5: 213-214) – to be a contributory factor in the mechanism of cranial osteopathy. She explores it in more depth when considering the cranial osteopathic relationship as a collaborative venture involving attunement and embodied empathy.

For Céleste, this collaboration is an interwoven, intersubjective, inter-embodied practical engagement. The observer would understand that the tactile sense plays a role in this work, but they would not grasp the extent or depth of this inter-hensile communication:

> "I mean your hands, your *hands* are the interface; they're the thing that's connecting you to the other being, but it's your whole being that, that is involved in that conversation" (pp. 5-6: 223-226).

It is – by definition – difficult to explain the prenoetic in words, but Céleste works hard to express the significance and the layers of meaning that emerge from this haptic conversation:

> "you know that you're not having a conversation that's at a kind of . . . umm cognitive or consciousness, err verbal level, not just verbal level; there's, there's a lot of layers to it" (p. 6: 235-238).

It is interesting to find within Céleste's depiction of this kind of multi-modal communication echoes of Richard's account of their haptic interchanges (already cited):

> "there are times when we can be sort of having a conversation, and she's not there at all, and I can look at her, 'cos she's on this side, on there, and I suddenly realise, that she is inside as well" (Richard: p. 19: 835-839).

I explore this multi-modal type of exchange within the Discussion chapter, and consider the question of whether it may involve not just a felt experience of shared sense-making but might also represent a congruent transfer of meaningful content – a reciprocal haptic hermeneusis.

5.18.2. Sarah: The cranial osteopathic relationship as intersubjective aesthetic engagement

Sarah collaborates with her patients, and speaks particularly of Eva: “I feel that we have quite a *rapport* and . . . I feel quite, sort of co-operative in a sense” (p. 22: 956-960). She tries to help her patients weave together a meaningful understanding of the status of their health: (“I think I probably . . . I try to sort of gather the threads together” (p. 22: 975-977)). She does this through a hard-to-explain process that involves finding the fulcrum where mind and body meet in herself and collocating it with the equivalent fulcrum within her patient: “so it’s sort of finding – in a way – feeling, feeling my way to find a kind of steady place – in myself – and in her” (p. 22: 967-969). This collocatory fulcrum is at the annexe where mind and body meet: “somehow trying to feel my way to . . . . . umm . . . to somehow find the, find the point where . . . sort of body and mind kind of meet” (p. 22: 964-966).

Is it in the very act of intersubjective entanglement that Sarah and Eva share a moment of intersubjective communion that completes the therapeutic concrescence? As Sarah expresses it: “and take that into one’s sensorium and, and, and, and things start to change, and the person knows that something’s happening?” (p. 7: 277-279).

As will be evident, there are reflections in Sarah’s account of this type of intersubjective communication in Céleste’s description of the multi-layered, multi-modal 'conversation’ that she reports having with her own patients, and there are also echoes in the accounts of Joe and Graeme, which follow.

5.18.3. Joe: The cranial osteopathic relationship as intersubjective aesthetic engagement

Joe explains that the relationship between the practitioner and the patient is paramount, regardless of the medicine or therapy in question:

> "do you know? I think the therapeutic relationship is the absolute key to – umm . . . to . . . any . . . positive therapeutic result, umm, and, at times, you know, I would go so far as to say it doesn't matter what modality the practitioner practices, that the, the quality of the relationship that they're able to make – umm, with the patient – is, is what will, umm, facilitate the positive outcome" (p. 26: 1149-1157).

He understands that human contact is vital for patients, especially in the context of dwindling provision of GP services:

> "our role as primary care practitioners is just gonna get more important, 'cos people, people need human relationship, and that comes back to the therapeutic relationship" (p. 35: 1555-1558).

The timbre of the relationship should be adjusted to the need of each patient ("it is really trying to meet the patient where they want to be met, in that moment" (p. 16: 672-673)), but should be able go deep when necessary: a good osteopath is one who can "establish a relationship which goes *under* the surface" (p. 26: 1165).

He communicates with his patients unverbally, as well as verbally: “I think of it very much as a dialogue, err, with the patient’s physiology” (p. 9: 385-386). The dialogue involves active, embodied listening, and the patient’s physiology is depicted as a third-person ‘it’, with its own agency, and, as already noted in Joe’s depiction of the mechanism of cranial osteopathy, somehow apart from the whole-self of his patient:

> “to that patient’s physiology, umm, to enable it to be able to tell the story in exactly the way it wants – umm, and set up, you know, the kind of treatment protocol, that it wants to, you know, that it wants to reveal” (p. 9: 392-395).

Joe tries to explain what embodied listening entails, since the word, ‘listening’, fails to fully convey the meaning he intends:

> “So, you know, that doesn’t necessarily convey a sensory experience, and that, that might not be what you’re asking – in terms of the sensory experience, umm, it’s more kinaesthetic . . .umm, it’s very much umm, aah, a motion-sense, I suppose . . . umm, or a quality-sense . . . umm, I don’t think it’s just palpatory [chuckles] – I don’t think it’s just a, a, a light touch, err, or a proprioceptive touch relationship – it’s, it’s a sensory relationship” (pp. 7-8: 308-332).

It is of note that Joe merges the idea of ‘listening’ with that of ‘relationship’ as he grapples with the sensory modes he considers to be in play during cranial osteopathic engagement

with patients, distinguishing between the kinaesthetic/motion sense, the discriminative touch/quality sense, the light touch sense and the proprioceptive sense.

5.18.4. Graeme: The cranial osteopathic relationship as intersubjective aesthetic engagement

According to Graeme, the osteopath is able to assess the patient by 'listening' to their resonance, acting as a sound-mirror to the frequencies emanating from their body's tissues, and recognising the vibrations that signify the qualities of health and unhealth:

> "listening with every fibre of your being to the resonances in every tissue of that body, if you can. And as you do that, the life story of . . . stuck areas . . . traum- old traumatised areas – comes out and then you begin to find what your diagnosis and treatment is" (p. 6: 235-240).

This quality of 'listening' requires a relationship of collaborative attunement, a psychotherapeutic concentration of presence, which Graeme has learned to cultivate:

> "I have to hold my own centre, not be part of you, but, from my own centre I listen to your tissues, and, that's being present . . . not just floating off – but being present" (p. 7: 305: 308).

Graeme explains more fully:

> "You are being part of it, because it's a little bit like being a catalyst – a little bit – and not exactly the same – 'cos you change yourself – the more I attune to your mechanism, as a patient – then to get there, I have to purify my own mechanism – which then goes to work and helps me – keeps me healthier too – so, so it's – it's the meeting of, of two mechanisms at a pla-

> at a wholesome place, where both benefit, in a way . . . although the prime aim, obviously is to help the patient – but you can't, you can't not change – you do change – listening to, working with patients" (p. 19-20: 851-861).

Here Graeme sketches out the structure of the intersubjective aesthetic engagement that characterises the cranial osteopathic relationship. It is a reciprocal coming together of the intelligent osteopath and the intelligent patient as co-agents participating in the project of disclosing health. It is of note that Graeme acknowledges the transformation in his own being as both a condition and an outcome of the therapeutic engagement.

5.19. Summary of Osteopath Theme 3

Each of the osteopath participants presents their sense of the cranial osteopathic relationship as an intersubjective aesthetic engagement.

- For Céleste, the sense of *intersubjectivity* is carried with her use of the term, "synchronisation" (p. 5: 214); the *aesthetic* nature of the relationship is conveyed through her description of her "whole being" (p. 5: 225) being involved in the conversation with the patient, whilst her hands are "the interface" (p. 5: 223-224); the sense of *engagement* is present in the idea of the collaboration in which both she and the patient get to work.
- For Sarah, the collocatory fulcrum is the *intersubjective* locus where her horizon of understanding merges with that of her patient's; the medium of her *aesthetic communion* with her patient is the work of her "sensorium" (p. 7: 277); the sense of *engagement* is found in her description of a co-operative rapport.
- For Joe, the sense of the *intersubjective* nature of the cranial osteopathic relationship is conveyed in his description of "trying to meet the patient where they want to be met" (p. 16: 672-673); the sense of the *aesthetic* suffuses his synaesthetic description of 'listening' to the patient's "internal physician" (p. 5: 192) – "it's a sensory relationship" (p. 8: 331-332). The sense of *engagement* is carried by his reference to "establish[ing] a relationship which goes *under* the surface" (p. 26: 1165).
- For Graeme, *intersubjectivity* is conveyed through his reference to the "meeting of, of two mechanisms" (p. 20: 856-857), the *aesthetic* quality of the cranial osteopathic

relationship is evident in his description of osteopathic 'listening' as "listening with every fibre of your being to the resonances in every tissue of that body" (p. 6: 235-236); the notion of *engagement* is crystallised in Graeme's description of "being part of it, because it's a little bit like being a catalyst" (p. 19: 851-852) which involves a self-transformation for the benefit of the patient.

The osteopath participants all identify the health-unconcealing outcome of the cranial osteopathic relationship.

- Céleste's account:

  "you go into those other realms, you know, you go into the, . . . umm . . ., seeing what's coming at you from the edges of the peripheral vision, or the peripheral sensation; you, you look to recognise what it is that's going; and then you try and put yourself in that place, and to actually be that feeling, or that texture, or that sensation; so that you're looking at it in a much, umm . . . broader and deeper and more complete way" (p. 7: 274-282).

- Sarah's account:

  "and being open to what you can't figure out . . . umm, I mean, at times, you know I've had people and I felt, I felt something, and it's like, "*This is a something – this is something*" and I simply don't know what it is" (p. 13: 547-551).

- Joe's account:

  "I guess it starts off for me, it starts off feeling like a tone . . . you know . . . umm . . . and then, maybe a collection of tones, or noises, you know . . . umm – and then something begins to organise, you know, and, umm, this shape will emerge, which may or may not be confined to the body – and then, within that, things start to move – again, and that may or may not be confined to the skin – umm – you know, things start to move in the space around, or within the body" (p. 36: 1609-1617).

- Graeme's account:

  "listening to thousands of mechanisms – in a non-judgemental way – to try and understand – what the system has to tell you, because it's, it's there in the system – you just have to – attune yourself – to be able to listen to it" (p. 19: 811-815).

I explore the concept of the cranial osteopathic encounter as an intersubjective aesthetic engagement, and the Super-Ordinate Theme to which it contributes, 'The meaningful osteopathic relationship', further in the Discussion chapter, proposing that it may be viewed first and foremost as a health-disclosing hermeneutic endeavour: a means of sense-making in which the two participants come to a prenoetic understanding of what ails the patient and what a sense of restored health might feel like. I also argue that the intersubjective aesthetic engagement can be thought of as both a medium of sense-making and the moment of symbolic enactivation of therapeutic change.

5.20. Introduction to Super-Ordinate Themes

In this section, I explore the higher-order themes that have emerged from my cross-case analysis of the accounts of the patient and osteopath participants, as they grapple with the epistemological and ontological questions concerning the phenomenon of cranial osteopathy. I organise the analysis into three Super-Ordinate Themes and bring to light the commonalities of experience and sense-making shared by the patients and the osteopaths. I highlight the distinctions, too, and picture the hermeneutic analysis as though it were transcribed onto facing pages of a book – the patients' lived experience on the verso and the osteopaths' on the recto. The Super-Ordinate Themes distill an understanding of the sense that osteopaths and their patients make of the phenomenon of cranial osteopathy.

1. **Making sense of sense-making**

This theme presents the epistemological and hermeneutic strategies of the participants and answers the question, '*How* do osteopaths and their patients make sense of cranial osteopathy?'

2. **Metaphors for mechanisms**

This theme gives an over-view of cranial osteopathy's ontology and proposed mechanisms of therapeutic effect and answers the questions, '*What* is cranial osteopathy and *how* does it seem to work?'

3. **The meaningful osteopathic relationship**

This theme distils the participants' sense-making about what they consider to be the most important feature of cranial osteopathy and answers epistemological, ontological and mechanistic questions.

5.21. Super-Ordinate Theme 1: Making Sense of Sense-Making

Both patient and osteopath participants have a meta-awareness of their sense-making frameworks and their hermeneutic strategies. They have constructed explanatory frameworks based on their prior experience, assumptions, knowledge and values. They oscillate between different explanatory structures, based in different epistemological traditions, in order to construct matrices that help with their hermeneusis of cranial osteopathy. They share a turn away from scepticism and towards pragmaticism in the face of their lived experience of the phenomenon of cranial osteopathy. They work to combine the sense-making and linguistic conventions of an empiricist epistemology based on a dualist ontology with a phenomenological openness to the experience of a monist mind-in-body and body-in-mind way of being.

The catalyst for this epistemological work is their encounter with the novel, intriguing and apparently implausible embodied aesthetic experience of cranial osteopathy. That which is usually in the 'background' – the interoceptive awareness, the sense of embodiment, kinaesthetic perceptions – comes uncannily to the foreground and demands hermeneutic work to make sense of it. The patient participants describe a sense-making paradigm in which 'proof' is constituted by what they know in their living body, while the osteopath participants describe a hermeneutic process that entails a distinctly phenomenological peripheral glance that opens up the unconcealment of the patient's health.

5.22. Super-Ordinate Theme 2: Metaphors for Mechanisms

Both the patient participants and osteopath participants use metaphor as a method for making sense of the mechanism or mechanisms of cranial osteopathy, that is to say, how they believe it works. The metaphors are linguistic devices that serve to transfer meaning – as it is understood – across the gap between the realm of what can be felt and the realm of what can be known. The metaphors are conjured from a range of sources. In the case of the patients, these metaphors are bricolage constructions that combine insights from their living-body experience of cranial osteopathy with knowledge about other forms of orthodox and alternative healthcare practices. The osteopaths have a more formalised frame of reference within which to construct their metaphors: their medical knowledge of anatomy and physiology, their interest in philosophy and physics and Sutherland's theoretical proposition; but – like the patients – they make reference to their living-body experience to render into articulability concepts that usually dwell within the sphere of tacit understanding.

The patient participants' metaphorical devices range from the mechanical (physiology as an engine) to the fluid (physiology as plumbing, central heating or irrigation systems) to the collaborative (the osteopathic relationship as a co-operative rapport). The metaphors do not *explain* the mechanisms of cranial osteopathy, but they help to *make sense* of them.

The metaphorical devices of the osteopath participants provide surface explanations for the mechanisms of cranial osteopathy and are based on principles that are mechanical (using a fulcrum; bringing motility to loci of inertia), physiological (facilitating the whole body

breathing; communicating with blood vessels) and psychological (projecting embodied empathy; sitting in a steady place).

The osteopath participants also provide a deeper layer of metaphor to convey the theme of the most important aspect of the mechanism of cranial osteopathy: that of a resonant attunement at the heart of the cranial osteopathic relationship – one that creates the conditions for the unverbal, meaningful coming together of the help-seeker and the help-giver in the project of making sense of the patient's distress or dysfunction.

5.23. Super-Ordinate Theme 3: The Meaningful Osteopathic Relationship

Both the patient and the osteopath participants highlight the therapeutic relationship as central to the mechanism of cranial osteopathy. For both the patient participants and the osteopath participants, the collaborative rapport they share embodies multiple levels of meaning: the very fact that they understand the cranial osteopathic relationship to play a role in the mechanism of cranial osteopathy means that it has *symbolic potency*; and the process of inter-embodied communication that functions as the medium for the relationship (and which is its hallmark) is one that generates *meaning* and unconceals health.

The patient participants set out their own individual sense of what is meaningful to them. The structure of this meaning-making is a surfacing to conscious reflection of a prenoetic acknowledgement of the reasons for their unhealth (on account of the hermeneutic work of the cranial osteopath), followed by an integration of this newfound understanding within the structure of their Lifeworld narrative.

The osteopath participants have a more explicit understanding of the nature and function of the meaningful osteopathic relationship: for them, the collaborative rapport is purposefully intersubjective and aesthetic: a pledgeful contract to work with the patient to help them find and realise a sense of (revealed) health.

5.24. Chapter Summary

The chapter began with idiographic pen-portraits of each participant then summarised the Patient Themes and Osteopath Themes that emerged from the IPA, along with the three Super-Ordinate Themes. For each Patient Theme and each Osteopath Theme, a table and a detailed account of each participant's contribution has been provided.

The Patient Themes are:

1) Frameworks for making sense of cranial osteopathy
2) Making sense of the mechanisms of cranial osteopathy
3) The cranial osteopathic relationship as meaningful rapport.

The Osteopath Themes are:

1) Cranial osteopaths' ways of knowing
2) Making sense of the mechanisms of cranial osteopathy
3) The cranial osteopathic relationship as intersubjective aesthetic engagement.

The Super-Ordinate Themes are:

1) Making sense of sense-making
2) Metaphors for mechanisms
3) The meaningful osteopathic relationship.

The IPA revealed that both patients and practitioners establish epistemological grounds for their sense-making about their embodied experience of cranial osteopathy (Super-Ordinate Theme 1: Making sense of sense-making), that they use embodied metaphor and linguistic meta-metaphor to understand their lived experience of cranial osteopathy (Super-Ordinate Theme 2: Metaphors for mechanisms), and that the mechanism of cranial osteopathy is considered by both patients and practitioners to arise from the therapeutic relationship (Super-Ordinate Theme 3: The meaningful osteopathic relationship).

CHAPTER 6: DISCUSSION

6.1. Chapter Introduction

Resulting from the hermeneutic analysis of the accounts of the present study's patient and osteopath participants are three Super-ordinate Themes, which I summarise briefly below.

1. **Making sense of sense-making**

This theme arises from a disquisition of the explicit and tacit epistemological positions and hermeneutic strategies that the study's participants engage, in order to make sense of the novel, intense and complex phenomenon of cranial osteopathy. The patient participants take a pragmatic position, once they have undertaken phenomenological work to understand the meaning and significance of their uncanny living-body experience of cranial osteopathy. The osteopath participants are also pragmatists, and maintain a phenomenological stance in order to make sense of the subtle and fine-grained aesthetic experiences involved in the practice of cranial osteopathy.

2. **Metaphors for mechanisms**

Both patient and osteopath participants generate embodied metaphors and verbalisable meta-metaphors so as to examine and make sense of the mechanism or mechanisms of cranial osteopathy. This theme covers the physiological, psychological and existential meta-metaphors used by the projects' participants to explain the seemingly implausible ways that cranial osteopathy might be said to have a therapeutic effect. The metaphors emerge from

bodily experience and surface to consciousness in a verbalisable form, finding expression in descriptive analogies with mechanical, electrical, energetic and metaphysical phenomena.

3. The meaningful osteopathic relationship

This theme crystallises the sense made by both the patient and the osteopath participants that the therapeutic relationship has a role to play in the mechanism of cranial osteopathy. The patient participants see the relationship as one of 'meaningful rapport' – an embodied collaboration that simultaneously helps them to understand what it is that ails them and enactivates the therapeutic change. The osteopath participants understand the relationship as an intersubjective collaboration that involves prenoetic aesthetic communication and the unconcealment of health.

I have generated these themes by dwelling closely in the accounts of my participants, committed to a phenomenological exposition of their sense-making about cranial osteopathy. I explore these ideas within the context of the existing literature on meaning-making in healthcare, the lived experience of embodiment as expressive of health, and the hermeneutic model of patient-practitioner collaboration.

When referring to the participants in this chapter, I use the convention of following their pseudonym with (P1-4) for the patients and (O1-4) for the osteopaths. So, according to this convention, Richard (P1) is the patient of osteopath, Céleste (O1).

6.1.1. Rethinking the nature of practice and the ontology of health

The hermeneutic exploration I have undertaken of the sense-making and meaning-disclosing endeavour of cranial osteopathy invites a re-orientation in thinking about the nature of practice and the ontology of health. Not only might there be a departure from the concept of osteopathy as a theory-driven and technique-mediated means of working with patients' anatomical and physiological bodies – including the contemporary discourse which incorporates and even *prioritises* psychological, social, political and economic factors as fractals that influence the patient's lived experience (Fryer, 2017; Penney, 2010, 2013); there might also be an onto-epistemological turn away from the concept of health as a resource or a commodity that can be generated or restored or reserved through the salutogenic activity of individuals or their healthcare practitioners. Instead, the reading that comes to me as both practitioner-hermeneut and researcher-hermeneut is that health is revealed to be an always already[31] present feature of all life, and that it is accessible to disclosure through the hermeneutic work of the osteopath and the patient. The expressivist ontology of hermeneutic realism allows for 'health' to be understood as given, and ready to find expression within the hermeneutic interplay between the osteopath and the patient.

In this expressivist reading, in which phenomena are always already 'given' and awaiting unconcealment, health is ontologically different from both "the absence of disease or

[31] A common translation of Heidegger's formulation, "immer schon", which accords with expressivist ontology – the idea that the feature is already there, but only becomes a meaningful phenomenon when one's intentionality is directed towards it (Sheehan, 2015, *passim*).

infirmity" (World Health Organisation, 1946) and "a state of complete physical, mental and social well-being" (*ibid*.) It is ontologically different from 'function', the concept so central to the practice of osteopathy (Tyreman, 2001). Instead, health is the underlying process whereby each animate form – each organism, every creature, every being – expresses its physiological capacity within its *Umwelt*.[32] Health is the operation of homeostasis and is never not present, from the moment of creation to the moment of extinction (Sheets-Johnstone, 2011). An osteopathic interpretation of the ontology of health that resonates with this description emerges in the discussion that follows below.

6.1.2. Making sense of cranial osteopathy: a hermeneutic model of practice

In this expressivist reading, it is the shared hermeneutic endeavour of the cranial osteopath and the patient to give health its expression. The medium of the expression of health is the hands-on practice that, as I hope to demonstrate, has three stepped functions, represented by the three Super-Ordinate Themes that have emerged from my interpretative phenomenological analysis undertaken within the current study (see Figure 6-1).

[32] The term is borrowed from Jakob von Uexküll, who influenced the phenomenologists in developing the idea that every creature has its own world of meaning, which he terms *Umwelt* (Thompson and Stapleton, 2009).

1) The first step is an **epistemological** one: to foreground the process of sense-making in the cranial osteopathic encounter. I present cranial osteopathic sense-making as:
   a) *embodied* (what is salient is registered within the ambit of the living body)
   b) *phenomenological* (what is salient is disclosed to the peripheral, phenomenological glance)
   c) *pragmatic* (scepticism is dissolved in the medium of lived experience).

2) The second step is a **semantic** one: the sense-making stance enables meaning to find *expression*, through the imaginative creation of embodied metaphors[33] as properties that emerge from the meaningful collaboration of the osteopath and the patient.

3) The third step is a **symbolic** one: the unconcealment of health in ways that may be both unique to the patient and also at the same time universal, galvanised within the context of the meaningful cranial osteopathic relationship.

[33] Etymologically speaking, the word 'metaphor' means to 'transfer across' or 'convey' – as though meaning were something to be ferried from the coast of one island of meaning to another. OED (2015) 3rd edn.

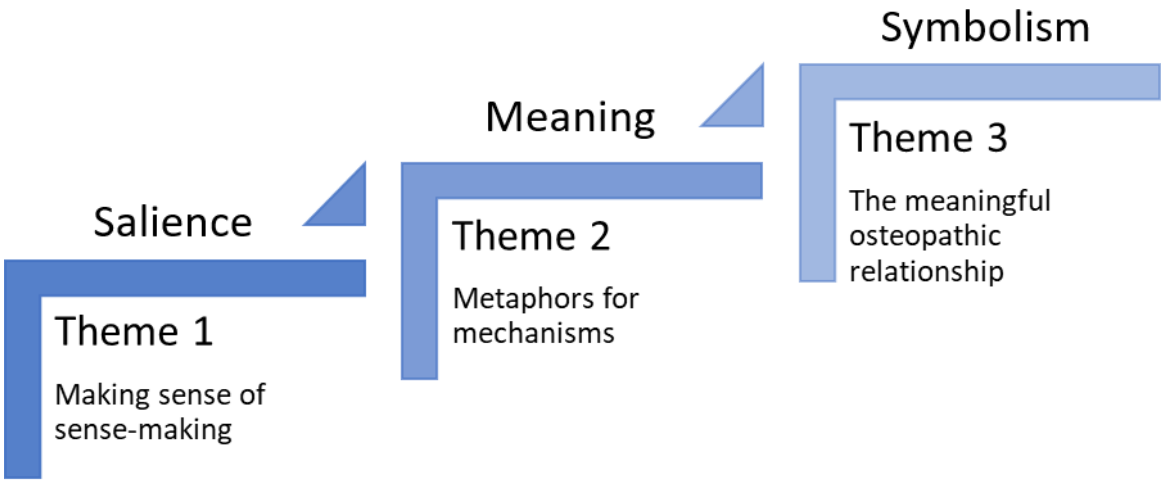

FIGURE 6-1 MAKING SENSE OF CRANIAL OSTEOPATHY

In the following sections, I discuss these three aspects of cranial osteopathic practice (represented by the three steps of Figure 6-1) within the context of the existing literature on embodied, enactive sense-making in healthcare, phenomenological accounts of the therapeutic relationship, the phenomenology and neuroscience of affective touch, and the contextual effects of healthcare; I also make reference to selected theoretical aspects of osteopathic practice. The guiding principle in selecting the literature reviewed has been to address the original research problem and the research question elaborated whilst pondering, 'What sense do osteopaths and their patients make of the phenomenon of cranial osteopathy?'

6.2. Theme 1: Making Sense of Sense-Making

The first theme distils the epistemological work undertaken by both the patient and osteopath participants of the study in order to evolve a pragmatic framework for phenomenological sense-making and embodied meaning-making in the face of the intense and novel aesthetic experience of cranial osteopathy. Using this framework, the participants are alert to the emergence of features of experience that might otherwise have remained in the 'background'.[34] Instead, intense embodied experiences register as salient to the amplified interoceptive awareness of the patient and the studiedly receptive, peripheral, phenomenological glance of the osteopath.

6.2.1. Embodied concepts

In the Literature review chapter, I have given a selective introduction to current theories of embodied and enactive sense-making.[35] I now highlight some of those concepts that give credence to the ideas advanced below. The starting point is to recall the argument that I set out in the literature review, that we, as humans, have the capacity – indeed the imperative – to express and understand 'concepts' at an embodied, prenoetic, pre-reflective level. Sheets-Johnstone (2011, p. xx), commenting on Cartesian dualism and its enduring influence

[34] See description of the Merleau-Pontian 'background' according to Shusterman (2008) in the Sense-making subsection of the Literature review, above.

[35] My focus on embodied sense-making and meaning-disclosure is a choice that is consistent with the phenomenological methodology and enactivist slant of analysis. It has arisen from my engagement with my participants' accounts. I do not mean to suggest that the participants do not engage additionally in more cerebral, rational or psychological meaning-making, such as that described by Smith (2018). They certainly do, and some account of this has been given in the Findings chapter. What is unique about the current study is that its focus is the therapeutic relationship that relies on unverbal, embodied communication rather than talk as the vehicle for meaning-making; this governs my decision to focus on embodied and enactive sense-making.

on western philosophy and culture, notes that we are blinded by our commitment to the dichotomy of "[l]ow-life bodies and high-life minds" and hence fail to accept the evidence of what she calls "corporeal matters of fact" (*ibid*., p. xxi). Later, the same author writes, "Our bodies are indeed semantic templates. Hence it is not surprising that fundamental human concepts are *corporeal concepts*" (Sheets-Johnstone, 2017, p. 10 [author's emphasis]).[36] These are, I argue, corporeal concepts with the potential for semantic content (rather than vague, unfathomable sensations), but only partially understood by the reflective mind.

6.2.2. Embodied aesthetic experience

Here is an example, the testimony of Eva (P2), who during her first cranial osteopathic treatment registered as salient some novel sensations:

> "I could feel it, I could feel it moving . . . so softly, it, it, and that's the thing, isn't it? It's the words, it's, that there was was twitches, I mean that's the only time I've had that twitching movement, and . . . and being quite tired after. So that was my first experience".

[36] The etymology of the word, 'concept' – the product of that which is 'conceived' – is instructive, originating as it does, in the Latin verb for take, seize or capture, 'capere' – an embodied act of grasping at objects in the world. Indeed, the etymology of many formal and colloquial English words for understanding have a corporeal origin, often involving the idea of grasping with the hand ('*prehendere*'). Even the etymology of 'cogitate' – as mental an act as it is possible to imagine – derives from the Latin idea of turning over a thought in the mind. The point here is that the language we use for most kinds of knowing originates with the idea of grappling with the world. OED (2015), 3rd edn.

Eva (P2) is recalling her experience and remembers the twitching movement that she could feel in her body – but at this stage the sensation was not fully realised as meaningful. Her phrase, "It's the words", suggests that the words to describe it eluded her. I follow up this example of Eva's, in the discussion of Theme 2, below.

Support for the idea that sense-making and meaning-disclosure arise within the matrix of the living-body comes from the enactivist example of motile bacteria which, by definition, are, like humans, animate forms.[37] As discussed in the literature review, there is the notion that the chemotactic motion of the bacterium towards sugar is an example of 'sense-making', given that sugar has significance to the bacterium as food within its *Umwelt* and it exerts its autonomy and maintains its existence through this 'sense-making' activity (Thompson and Stapleton, 2009). Thompson and Stapleton (2009, p. 26) consider embodied cognition as "more a matter of adaptive self-regulation in precarious conditions than abstract problem solving" (although they do not provide evidence or further argument for the thesis that embodied cognition only arises in "precarious conditions").

The theory that we humans have embodied concepts, and undertake embodied sense-making in a drive to maintain homeostasis, has general acceptance within the field of enactivism, although there remain some schools of consciousness theory that reject this notion (Gallagher, 2017). I have explored the fundamental principle that 'bodies have

[37] I discuss this concept in the Literature review chapter.

concepts', advanced by Sheets-Johnstone (2011, 2017), Gallagher (2017) and others, in the initial review of literature and theory, above. The idea is consistent with the findings of the current study, which I now go on to explore further, within the discussion of Theme 2 and Theme 3 that follow, below.

6.3. Theme 2: Metaphors for Mechanisms

6.3.1. Metaphor: the semantic shift from salience to meaning

The step from the first theme to the second theme represents the semantic shift from that which is registered as salient to that which is understood as meaningful. This second theme title plays with words. I outwardly reference the metaphors that the patient and osteopath participants use to demonstrate their understanding of the mechanism or mechanisms of cranial osteopathy, but I also propose that the experience and expression of the metaphors at an embodied level – such as corporeal concept of integration, discussed immediately below – actively constitutes a mechanism in its own right that partly constitutes the therapeutic effect of cranial osteopathy.[38]

6.3.2. The embodied metaphor: example of integration

An example of the semantic shift is found in the testimony of Eva (P2) who, when discussing her response to ongoing cranial osteopathic treatment, describes her sense of renewed embodiment – a sense of the parts of her body feeling interconnected again. She is no longer struggling to express what it is like to feel twitches in her body – or what they portend. She now has an understanding of the meaning of the feeling; she contrasts the sense that she has of her body before and after treatment – she "know[s] deeply that difference" (Eva; P2. P. 6: 262). Before, she describes a state of disconnection, "kind of the head on the body [chuckling] . . . with the various aches" (*ibid*. pp. 9-10: 844-848); after she

[38] My use of the idea of the embodied metaphor owes to Gendlin (1962) and Lakoff and Johnson (1980a and 1980b), as discussed in the Literature review chapter.

feels “all joined up” (*ibid*. p. 9: 843) with “everything connecting [exhales]” (*ibid*. p. 9: 375) and “more *connected*, I, I breathe differently” (*ibid*. p. 19: 808). Here, according to my analysis, we have a person with an embodied sense of internal dislocation, feeling poorly aligned, with separate body parts signalling discomfort. The corporeal concept she has after cranial osteopathy is ‘integration’; she is now one person in one body, with all its parts working together as they should; she now knows how to breathe again.

6.3.3. Metaphors and meta-metaphors

The participants in the current study acknowledge their struggle to use precise and expressive language to convey a sense of their experience and understanding of cranial osteopathy. They undertake somatic-semantic hermeneusis to depict their experience in vivid metaphorical constructs, whilst admitting the struggle to find the words to say what they intend. They portray the mechanism of cranial osteopathy as the operation of systems (whether man-made – e.g. plumbing – or physiological – e.g. the oxygenation of tissues), or as a more metaphysical – or even magical – manifestation of health. I propose that the linguistic expressions are meta-metaphors, whilst the original metaphorical work – as exemplified by the case of Eva (P2) above – is that which constitutes the prenoetic, embodied grasp of the problem and the understanding that the resolution is ready to hand. I propose that this work occurs within the context of the therapeutic collaboration with their osteopath, as the patient comes to know – within their living body – that health is always already given to them. I discuss the concept of this embodied metaphorical work further in the section on Theme 3.

6.3.4. Meta-metaphors for the lived experience of cranial osteopathy

The meta-metaphors may already have arisen during the course of the cranial osteopathic encounter, may have been vocalised and may have been discussed by the patient and the osteopath, as in the case of Richard (P1) and Céleste (O1) when he felt a sense of fluid cascading down his spine:

> "And it literally was like, umm . . . something has cascaded all the way down each side of my spine, and I said to her [i.e. Céleste], "That is just like rivers of blood! What on earth are you doing?" And she said, "That's exactly what I'm doing"" (Richard; P1. p. 13: 567-570).

The meta-metaphors may have found their proto-expression during a cranial osteopathic encounter; but their full articulation often seems to occur for the first time during my interview with the participant, which I believe is the case in Joanna's (P3) account of her response to cranial osteopathic treatment with Joe (O3):

> "I mean, sometimes it turns into muscular, and it's like a shortening, and it's like a – yeah, well, kind of pull . . . . . umm, but it can also, I've also felt it like it feels like, literally water running down the inside of my, my bones . . . umm . . . what else have I felt? . . . . . Oh, sometimes it just feels like it's sort of – ah! Sorry, I know we're on tape, I can't really describe it, it's, it's like a *clicking* open; it's like . . . umm . . . . . What's it like? . . . . I can't think of anything that would . . . but it, it, it's like tiny little, like

> almost 5 mil . . . click and relax, click and relax, click and relax, click and relax, and it just happens, ke-too ke-too ke-too ke-too ke-took" (Joanna; P3. p. 7: 286-297).

The examples of Richard (P1) and Joanna (P3) cited above are examples of extended metaphorical devices that give expression to intense and novel interoceptive, kinaesthetic experiences. An example of an osteopath participant similarly using meta-metaphor to explain their experience is found in this extract of Joe's (O3) transcript, which records our interchange when I asked him to explain to me what it feels like to perceive a vibrational tone believed to be emitted by a mass of peptides within a patient's body:

> "Joe: No, no, no, that's fine, it's just like, it's just like – if it was a musician, they would be able to start to go, that's a C minor, you know, it's got a pitch – it's like playing a note . . .
>
> Mandy: And I think I'd like to understand how . . . how it f-, how it feels to you, how you *perceive* . . . umm, the pitch, or the tone, or the quality of that peptide frequency . . .
>
> Joe: Hm-hm. I guess it's like a vibration, you know. So, if you put your hand on the washing machine, okay, and it's doing a slow spin, it has a certain quality, doesn't it?" (Joe; O3. p. 11: 456-466).

Joe (O3) begins with a musical metaphor for how we can hear a sonic airwave vibration and then reinforces it with a mechanical metaphor for how we can palpate a lower-frequency airwave vibration. To my ears, the musical metaphor is more abstract – and less concrete – than the mechanical metaphor; the latter conveys to me as both practitioner-hermeneut and researcher-hermeneut a sense of what it feels like for Joe (O3) to palpate a tone in his patient's tissues.[39]

6.3.5. Relationship between the meta-metaphor and the embodied metaphor

The meta-metaphors are functional, and shed insight into the process and content of the lived experience of cranial osteopathy, but they do not *explain* the mechanisms of cranial osteopathy, which remain elusive to a concrete, objectivist, theoretical understanding on the part of the patient and osteopath participants. Yet, despite the elusory nature of the mechanisms of cranial osteopathy, an appreciation of the metaphorical and meta-metaphorical structure of the cranial osteopathic encounter does seem to *illuminate* the experience of the patient and the osteopath in their shared sense-making about the phenomenon.

This proposal is supported by Finlay (2015, pp. 338-339), who suggests that metaphors arising in a psychotherapeutic relationship "offer a way of seeing a reality indirectly and in a different way that, in turn, allows new meanings to come into being". Finlay (2005, 2006,

[39] Here is a transparent example of my interpretation being filtered through my fore-understanding. I discuss this issue later within the current chapter.

2015), as indicated within the literature review, is particularly interested in metaphors that give expression to a client's sense of their own embodiment, as well as those that surface in the therapist herself. In the context of cranial osteopathy, what is of interest is not merely the metaphors that find linguistic expression – which I am calling the meta-metaphors – but those that seem to find prenoetic, embodied expression at the time of their emergence, which can only be recalled and recounted obliquely, after the event, with intense, imaginative work. Finlay (2015, p. 342) is not, to my knowledge, a practitioner who works with hands-on touch, but she is one who is very sensitive to her own and her clients' living bodies and she claims to use not only metaphors, but also "any associated imagery or embodied sensations" to "act as sensors, as detectors of meaning that help [her] empathize with, interpret, and understand" the experiences of her clients. I argue that this process of intersubjective haptic hermeneusis occurs in the context of the meaningful cranial osteopathic relationship, which I go on to explore in the discussion of Theme 3.

6.4. Theme 3: The Meaningful Osteopathic Relationship

The third theme represents the enactivating step that realises the embodied metaphor and the verbal meta-metaphor to catalyse the unconcealment of health in a transaction that has symbolic potency – or, in the usage of Tambiah (1973/2017), 'illocutionary force'[40] – at the same time that it generates a meaning for its participants that has both unique and universal qualities. Another way of saying this is: *that* it has meaning is *why* it matters. In this reading, I propose that the structure of the meaningful osteopathic relationship is one of archetypal human consociacy[41] situated within the domain of human experience associated with the primal and physiological tendency towards health, mediated through living-body homeostasis and the meaning-making matrices we construct to make sense of our existential confrontation with our finitude.

6.4.1. Intercorporeity within the cranial osteopathic relationship

Merleau-Ponty (cited by Dahlberg, Drew and Nyström, 2001, p. 69) uses the concept of 'intercorporeity' to describe the meaningful embodied relationship between people: "a body encountering its counterpart in another body which itself realizes its own intentions and suggests new intentions to the self". This notion finds a contemporary explanation within the framework of enactivism: "Intercorporeity involves a mutual influence of body schemas . . . a reciprocal, dynamic, and enactive response to the other's action" (Gallagher,

[40] I introduced this concept in the Literature review chapter; this term was coined by the ordinary language philosopher, J.L. Austin, to refer to the implicit meaning that accompanies overt statements. I transfer this concept to the realm of unverbal communication.
[41] A term I have adapted from Schutz (Barber, 2018).

2017, p. 77). I interpret this "mutual influence of body schemas" as the metaphorical process of resonance or attunement, in which, for example, an embodied concept such as 'stillness' or 'centredness' or 'relaxation' can be conveyed from living body to living body. I now illustrate the concept of the meaningful osteopathic relationship as one involving attunement (and therefore the capacity for the mutual influence of body schemas).

6.4.2. The meaningful osteopathic relationship is one of 'attunement'

The metaphor of 'attunement' surfaces in the accounts of all of the patient participants (see patient sub-theme 2.4. 'attunement metaphor') as well as the accounts of all of the osteopath participants (see osteopath sub-theme 2.1. 'intersubjective resonance'). I focus on the accounts of Richard (P1) and Céleste (O1), who make explicit use of the concepts of being in tune, and Ann (P4) and Graham (O4), who also refer to attunement.

6.4.3. Richard and Céleste

Richard (P1) relays an explanation given to him by Céleste (O1), which he has recorded in his diary, that attempts to make sense of his intense interoceptive experience of cranial osteopathy:

> ""And she says", umm, "'I am merely the conductor. Your body does the rest. Parts are not singing in harmony. Some are not in **tune**"."

Later on, he tells me of his instinct that one particular treatment session was less effective than previous ones, and that he had reflected on it and concluded, "you've sometimes gotta be in **tune** as well as she". In the first example, the sense of attunement arises within a

metaphor about the synchrony and harmoniousness of musicians in an orchestra. In the second, it is more evidently about the rapport between Richard as patient and Céleste as osteopath: and on this occasion, Richard (P1) attributes the problem to his own receptivity or attitude or commitment to the session (each of these readings could apply equally).

In her own account, Céleste (O1) does not use the words, 'tune, 'attunement', or the meta-metaphor of the orchestra. She does, however, refer to a "non-verbal synchronisation with another being" (Céleste; O1. p. 5: 213-214), which she also describes as a "conversation" (Céleste; O1. p. 5: 226, 227, 236, 239) that is conducted through her hands. She conveys the sense of establishing a synchronised, harmonious rapport in order to communicate meaningfully with her patients.

6.4.4. Ann and Graeme

Ann (P4) has a similar insight to that of Richard's (P1) when she expresses her understanding that it is necessary to be "in **tune** with the person [i.e. the osteopath]" (Ann; P4. p. 31: 1383-1384) and to have a "rapport" (*ibid*. 1387) with him for the treatment to work. Graeme (O4) presents an extended metaphorical discourse to convey his understanding of the role of 'attunement' in a cranial osteopathic encounter, and in his words, 'attunement' has both musical and intersubjective meanings:

> "you just have to – **attune** yourself – to be able to listen to it – and of course, the more you **attune** yourself, it's like a musician learning their instrument – the more they do it, hopefully, the better they get at it – so

you, you're the instrument in a way – and so, this and so, I've had people say that they don't think it's to do with self-development – I think that's rubbish – it's got to be, it's got to be to do with self-development – otherwise how do you, change the instrument? How do you **attune** the instrument better? . . . . It's a, it's, it's, a **tuning** of oneself to listen, and you can do that, through your hands, or if I wish I can, I can sit here and I can start to begin to **tune** into how your system is working – that is in a more, umm, right-brain, whole, whole – if I want to be very exact, I would always use my hands, of course – but, umm – yeah, it's got to be an **attunement**, I think" (Graeme; O4. p. 19: 813-837).

In this rich example, Graeme (O4) uses 'tune into', 'attune' and 'attunement' to indicate having receptivity to hearing what the patient has to disclose in an intersubjective embodied manner, to become practised at the ability to hear the patient in this manner, and to become skilled at discerning expertly what sort of receptivity to offer. In this account, 'attunement' also requires an ability to self-attune: to become intentionally present to one's own living body.

6.4.5. Summary of the example of 'Attunement'

I propose that the meta-metaphor of attunement found in the accounts of the study's participants – whilst it represents multiple expressions of empathy, collaboration, resonance, understanding and synchrony – is a linguistic articulation of a primary embodied shared sense of intersubjective harmoniousness that becomes manifest during a cranial

osteopathic encounter – and that it bears meaning as well as illocutionary force. How this may happen cannot be explained by the current study. It is possible, however, to imagine a mechanism in which the patient responds to the unverbal cues of the osteopath (such as their stillness, their level of attentiveness, their gentle touch) and begins to embody a psychological, physiological and phenomenological disposition towards feeling better. A further layer of the example of 'attunement' is that it is often used as a meta-concept to describe the class of therapeutic relationship experienced within psychotherapy (Röhricht, Gallagher and Hutto, 2014), complementary and alternative therapies such as Reiki (Lee-Treweek, 2005), and even medicine (Svenaeus, 2000a, 2000b). I propose that the cultural currency of the concept of 'attunement' does not detract from the value of its usage to describe the meaningful osteopathic relationship, but that it opens up more questions about the structure of human consociacy that I discuss below.

6.5. Hermeneutic Model of Cranial Osteopathy

Reflection on the three Super-Ordinate Themes that have emerged from this interpretative phenomenological analysis leads me to the conclusion that it is warranted to consider cranial osteopathy as first and foremost a health-revealing hermeneutic endeavour:[42] a means of sense-making and meaning-disclosure in which the two participants come to a prenoetic understanding of what troubles the patient and what a sense of health might feel like. I propose that the hermeneutic model of cranial osteopathy is characterised by an embodied, enactive communion co-constituted by patients and their osteopaths through therapeutic attunement, i.e., the rich multi-sensory experiences afforded through touch, proprioception, kinaesthesia and interoception. I see it as a Gadamerian *Horizontsverschmelzung*[43] (Svenaeus, 2000a, 2000b, 2003) communicated by metaphor, a somatic-semantic medium in which the transformative moment of symbolic potency is created with illocutionary force.

This hermeneutic model of cranial osteopathy is supported by three recent papers that consider the unverbal and tactile aspects of therapeutic relationships within the practice of physiotherapy, osteopathy and, specifically, cranial osteopathy. I described and analysed the contribution of these papers in the Literature review chapter (see discussion of Øberg, Normann and Gallagher (2015), Consedine, Standen and Niven (2016) and Stuart (2016))

[42] I acknowledge my debt to the work of F. Svenaeus, who has articulated a hermeneutic framework for clinical practice; see, particularly, Svenaeus (2000a, 2000 b, 2003), as introduced in the Literature review and Methodology chapters.
[43] Discussed in the Methodology chapter and again, below.

and find that emerging from this body of work is the concept of embodied, enactive, disclosive clinical reasoning and haptic hermeneusis that resonates with my hermeneutic model of cranial osteopathy, which I set out as a step-by-step process, below.

6.5.1. Hermeneutic model of cranial osteopathy: making sense, disclosing meaning, unconcealing health

I now describe the meaningful osteopathic relationship model of embodied, enactive sense-making, meaning-disclosure and the unconcealment of health with reference to the lived experience of the participants of the present study. The process is illustrated at Figure 6-2, below.

a) Rapport

The patient indicates what troubles them by telling their story and indicating their distress:

> "Céleste does an umm half an hour assessment as to your medical history and how you've been treated and what's gone- happened, so that she doesn't interfere with what . . . she doesn't want to interfere too much . . . without knowing what she's, umm, dealing with" (Richard; P1. p. 2: 71-77).

> "So, you know, she'll always check-in with how I am" (Eva; P2. p. 12: 517).

> "[W]e talk at the beginning; we always talk at the beginning" (Joanna; P3. p. 6: 235-236).

The cranial osteopath hears the story with open, plenisentient receptivity:

> "'Listening' is . . . . . listening with every fibre of your being to the resonances in every tissue of that body, if you can". (Graeme; O4. p. 6: 235-237).

> "[In response to my question about listening means listening with the ears] *Yeah*, but well both, yeah, with the ears but also with . . . you know, also with, in a, in a . . . listening to the – yeah, listening on different levels, no, I don't think it is just with my ears – it's kind of listening – almost listening to the, listening to the story, listening to what's being told . . . listening to what – what's, umm . . . it's sort of how and where we are at this moment in time, or what's – listen to what's . . . listening to find a sort of way in, in some way" (Sarah; O3. p. 23: 989-996).

The rapport that is established between the cranial osteopath and the patient is archetypical of the therapeutic alliance, but is characterised by the osteopath's aesthetic openness, and not only an interest in the patient's narrated story: the osteopath and patient are now inhabiting a sphere of mutual participation.

b) Collaboration

The patient lies down on the treatment table and relinquishes sole responsibility for the work of understanding the experience of their symptoms. There is the understanding that not only are they being heard but that the cranial osteopath is actively seeking to understand them and the source of their distress:

> "I also gleaned in the, in the first few sessions that she would go back to my feet, having gone from my feet to my side, and she would be one hand on there and one hand underneath, and she had found, umm, within a couple of sessions that there was something wrong with my [physiological function]" (Richard; P1. p. 7: 288-293).

> "You know, she'll, she tunes in very quickly, just, even just looking at me, and often it *is* – often the pelvis . . . you know, the thing is, I often don't even *mention* the pelvis, because I'm just living with it . . . . So she will work, umm, generally . . . yeah, will work, most often, umm, sacrum, less on the head in a way, I mean she does work up – there, she'll co-, you know, come up there, but a lot will be ju- just get things moving . . . notice the lymph, you know, getting the lymph moving, there's a . . . it does get all caught up here, or make sense – so often . . . umm, you know sometimes she can, has to get in there" (Eva; P2. pp. 12-13: 529-546).

Although there has been some introductory talk, the collaborative work really begins when the osteopath has their hands on the patient, who engages in the hermeneutic work by participating in the hermeneutic project through their expressive body.[44]

c) Dwelling

The cranial osteopath optimises their listening stance by finding a point of stillness within their being, which I propose to be a form of living-body-mindfulness that predisposes to existential and physiological entrainment between the two individuals, and which Finlay (2015, p. 342) calls 'dwelling':

> "feeling, feeling my way to find a kind of steady place – in myself – and in *her* – umm . . . from which we can – umm . . . from which we can *work*" (Sarah; O2. p. 22: 968-970).

The osteopath finds a neutral place within themselves in order to find a way of dwelling with – without invading – their patient.

[44] I make reference to Consedine, Standen and Niven (2015) with the phrase, 'expressive body'.

d) Hermeneusis

The cranial osteopath perceives receptively and actively, directly and peripherally – and simultaneously at both a microcosmic and a macrocosmic level – to manifest within their sense-making matrix a *Gestalt* reading of health:

> "I think it's the, the balance between right and left brain, and I think that you have to start completely right-brain and then, as an area begins to float up, then you can left-brain towards it, but you have to be able to maintain the right brain at the same time . . . so, you can't, if you listen to this and think, "Ah, that sphenoid, is that sphenoid?" – then, yeah, you might find out a bit about the sphenoid – but you have no idea of the context of how it's working in the whole body – nor the rest of the whole body – and you've changed its function, and it's, what it can tell you anyway – 'cos of that over-attention. So, the balance between left and right brain, I think" (Graeme; O4. p. 6: 247-259).

Using their bodily senses of touch, proprioception, kinaesthesia and interoception – in addition to the intuitive-affective sixth-sense that Finlay (2015) describes – the cranial osteopath perceives sensory signals that register as salient and meaningful, some signifying health and others signifying unhealth. I refer to this process as 'haptic hermeneusis':

> "There's a particular quality of the bone, it's like – I don't know, a funny sort of hollow . . . umm . . . I don't know, it's like a sort of, it's like a funny sort of vibration . . . it's like a sort of, it's like rather than breathing, the bone's kind of, it's almost like a sort of high-level . . . discomfort-vibration, just, it's like the bone doesn't feel, it doesn't feel right, that doesn't sound very but there's something that doesn't feel – it, it, it's not – it doesn't feel juicy, it feels – umm – a bit high-pitched and irritable – traumat – like a sort of trauma-held" (Sarah; O2. p. 11: 454-463).

This hermeneutic work is emphatically at an embodied level and may not emerge to reflective consciousness. As evinced by the osteopath participant, Sarah, it requires great effort to convert the experience into verbal form.

e) Relief

The sense of relief is often an embodied one, understood by the osteopath:

> "[T]here was a sense of his body just going, "Aah, thank god, help's arrived". And it probably didn't matter what sort of help it was . . . [patients] don't seem to mind too much what sort of help you offer" (Céleste; O1. p. 10: 409-414).

It is experienced and expressed by the patient – in this case, as a wave of relaxation:

> "there's something, it's that *wave*, that, that *wave* that goes through, you know which is, you know it's the spinal fluid, isn't it? The thing is, that whole, everything connecting [exhales] [whispers:] in a relaxed manner yeah". (Eva: P2. p. 9: 372-376).

The experience of relief is at an embodied level and may not emerge to reflective understanding – although in the case of Eva, cited above, it plainly does.

f) Attunement

There is a felt reciprocity that is experienced as a resonance that has both the illocutionary force of symbolic potency as well as the content of the collaborative meaning-making:

> "maybe it is just that thing where . . . . . your body just needs . . . contact with somebody to heal itself" (Joanna; P3. p. 9: 366-367).

> "Umm, and so when I went to see Graeme, I remember lying on that couch and, I said to him – anyway he did, you know, and I got up. I said, "You're like Jesus!"" (Ann; P4. p. 15: 630-633).

'Attunement' describes the condition of metaphysical potency in which the embodied collaboration between the patient and the osteopath is at its apogee, as their horizons of meaning merge.

g) Health is unconcealed

There is a sense that, for the patient, their symptoms now make sense: the confusion of not understanding abates and they can breathe a metaphorical sigh of relief; they are no longer gripped by their symptoms; they have a sense of their physical body functioning again.

> "you feel you're aware of the rest of your body in a, it's a, it's so subtle . . . but it's, it's like it's, you-you've filled up – there's a . . . . . yeah, there's a . . . ohh . . . . . so the knee and the hip are now joined because you have a *sense* of the space between . . . you know, umm, so the blending is either because there's been a shift of movement – the move-, you know, things have just . . . I don't know – calmed down, or just the fact that you're all connected – it's not these disparate pains – they're not – just kind of been *smoothed* out – smoothed out [chuckles]" (Eva; P2. p. 20: 870-880).

The unconcealment of health occurs when the hermeneutic work is completed, when meaning is disclosed and health can once again find its expression.

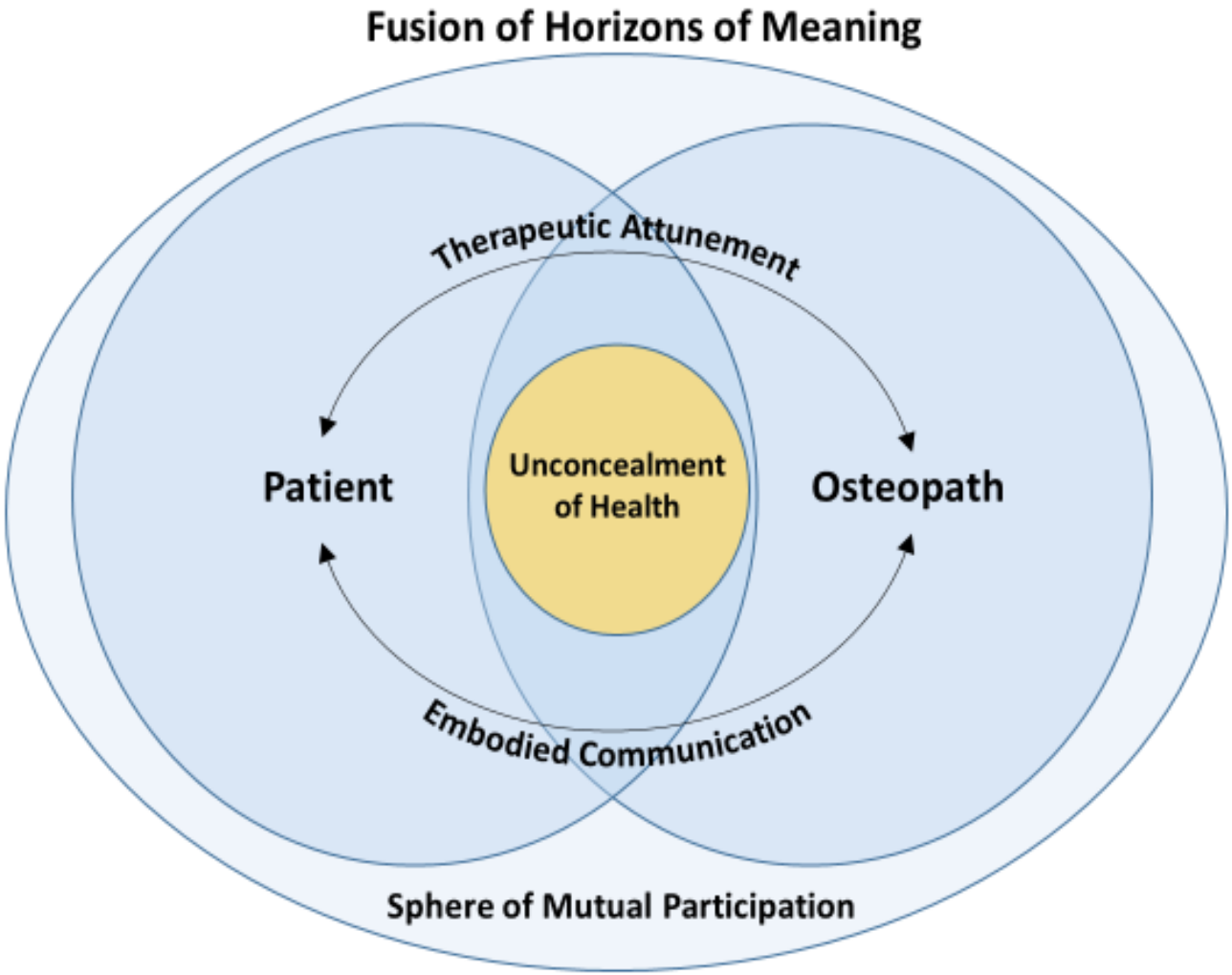

FIGURE 6-2 HERMENEUTIC MODEL OF CRANIAL OSTEOPATHY

6.5.2. Theoretical structure of the hermeneutic model of cranial osteopathy

The embodied, enactive sense-making and meaning-disclosure that arises in the context of a cranial osteopathic encounter, as illustrated above in Figure 6-2 may be illuminated by the model of enactive, intersubjective, participatory sense-making proposed by Fuchs and de Jaegher (2009), introduced in the literature review. In their oft-cited paper, the authors examine the structure of intersubjective sense-making between individuals, claiming that it involves a bodily empathy that they call 'mutual incorporation', suggesting an embodied resonance in which the sense-makers resonate – or even *merge* – in their understanding.

Citing Fuchs and de Jaegher (2009), Gallagher (2017, p. 77) describes the meta-semiotic sense of understanding that arises during the process of intersubjective sense-making as a reciprocal attunement emerging as a distinct property alongside the process of enactive, embodied communication. It is this model of enactive, embodied sense-making – which produces both semiotic content and an overlying meta-semiotic sense of relief – developed variously by Gendlin (1962), Greenspan and Shanker (2004), Fuchs and de Jaegher (2009), Trevarthen (2015), Taylor (2016) and Gallagher (2017), that describes the hermeneutic structure of the meaningful cranial osteopathic relationship identified in the present study.

I have illustrated the hermeneutic model of cranial osteopathy in Figure 6-2 and now present an analogy that might be more commonly experienced and therefore more readily understood: an interchange between a massage therapist and a client. After hearing about the patient's back, neck and shoulder stiffness, the therapist runs their hands over the patient's shoulder musculature and detects certain anomalous textures, whether deep in

the muscle bellies or superficially within the sub-dermal structures, and begins to alter the pressure of their stroke to highlight to the client the 'knots' and 'gristle' that have appeared within their muscles. The massage therapist is relating to the patient and their body in an expert mode, working with the patient's tissues that are ready-to-hand (in Heidegger's ontological mode of *Zuhanden*), making sense of the patterns and textures without reflective thought. The patient winces with recognition, understanding these painful textural irregularities as the source of discomfort and possibly of dysfunction. The patient's symptoms make sense to them now. They have both the content of the concept that the knots in the muscles are responsible for their symptoms, along with the meta-semiotic relief of knowing that their symptoms make sense (and are not, as they might have put it, 'just in my mind').

In the manner articulated by Øberg, Normann and Gallagher (2015), the pre-reflective communication may remain in the unverbal sphere, but may also find accompanying linguistic expression (whether vocalised or not). What I want to emphasise is that this proposed structure of communication is embodied, prenoetic and unverbal, which is to say that although it can be considered corporeally conceptual (Sheets Johnstone, 2011), it is abstracted from overt symbolic representation and from language;[45] indeed, this level of communication may be considered to be ontologically prior to language (according to

[45] Although it might also be said, in the manner of the proposition of embodied cognitive linguistics (see the discussion of Gendlin (1962) and Lakoff and Johnson (1980a, 1980b) in the review of literature and theory), to underpin language.

Greenspan and Shanker (2004) and Taylor (2016)). For now, the relationship of the felt experience to its linguistic expression is not of the utmost importance; what we have is a model for understanding how the sense-making happens in the participatory way that can be called 'mutual incorporation', as proposed by Fuchs and de Jaegher (2009), yet the understanding is based on a haptic relationship that stimulates a multi-aesthetic intercorporeal communication, rather than just the senses of vision and hearing, the modalities referenced by Fuchs and de Jaegher (2009).

6.6. The Unconcealment of Health in Osteopathic Theory

One rhetorical device in early osteopathic writing about health is to identify it with 'Nature' (Paulus, 2013). In this reading, 'Nature', is early-twentieth-century short-hand for the physiological 'forces of healing' (Paulus, 2013, p. 13). Paulus (2013) interprets A.T. Still's understanding of health and healing as the work of 'Nature' (so capitalised), and proposes an account of healing as something that "emerges from what is healthy in us rather than from what is diseased" (*ibid*., p. 13). This is attested by the oft-quoted (and, as demonstrated by Stark (2012, p. 371), often misquoted) aphorism of Still's, written in 1902, "To find health should be the object of the doctor. Anyone can find disease". This concept would have had wide-spread acceptance in turn-of-the twentieth century USA, and was echoed by the naturopathic principle, *vis medicatrix naturae* ('the healing force of nature') (Logan *et al.*, 2018, p. 368). Even in the late twentieth century, Gadamer (1996, p. 89) was describing medicine as the science that "must participate in the wonderful capacity of life to renew itself, to set itself aright" and claiming that "every treatment stands in the service of nature" (Gadamer, 1996, p. 110), a belief that finds its echo in Still's aphorism. In the latter

part of the twentieth century and early twenty-first century, Still's sentiment seems to have been drained of meaning by facile overuse (Stark, 2012) in defence against the discourse of evidence-based medicine. Yet, considered anew in the light of an expressivist ontology, the phrase has another resonance: doctors (i.e. osteopaths and cranial osteopaths) can approach their work with the intention of unconcealing health that is always already there. In the words of cranial osteopath, Rollin Becker (1997, p. 51): "Life in the body and its manifested motion and movement is working as a unified whole mechanism to manifest health". This approach departs fundamentally from the predominant western nosological model of medicine that reifies experiences of unhealth into disease categories. Whether this reversion to the principle of unconcealing health can find relevance in twenty-first century osteopathic practice remains open to question, and is explored further in the current chapter, below.

6.7. The Unconcealment of Health in the Current Study

6.7.1. Hermeneutic expression of health in a cranial osteopathic encounter

The ontologically expressivist account of health-disclosure that emerges from the current study ascribes a particular value to the findings of hermeneutic cranial osteopathy. The findings are those features that emerge as meaningful at the specific time and in the specific place of the cranial osteopathic encounter. These findings would, in other models of healthcare practice (for example, physical therapy or 'structural' osteopathy), represent the 'findings' of the so-called 'objective' physical assessment, within the context of the so-called 'subjective' history, and contribute to a diagnosis (Quinn and Gordon, 2003). I propose that what is understood to be meaningful in any cranial osteopathic encounter (whether to

patient and osteopath individually, or to patient and osteopath jointly) can be viewed as an expression of both unique and universal qualities of health. An example of what might be unique is Richard's (P1) experience of fluid coursing down his legs during a cranial osteopathic encounter with Céleste (O1), or Joanna's (P3) 'raft' of sensory and affective feelings that arise during her cranial osteopathic encounter with Joe (O3). What might be thought of as universal are experiences that relate to the existential primes of embodied human health, such as being upright, moving, walking – and, as is common to all of the study's patient participants, breathing in a more satisfying way. The distinction between the hermeneutic findings that arise in a cranial osteopathic encounter and those that contribute to an orthodox medical diagnostic framework is that the former are always situated and idiographic – they cannot be abstracted, objectified and standardised.

6.7.2. Examples from the current study

In response to my question about how she could feel the quality of aesthetic phenomena emanating from the patient, the cranial osteopath participant, Sarah, grapples with the difficulty of explaining how the expression of health reveals itself to her:

> "Feel what we feel? . . . Through my hands, through, through – oh . . . . . such a hard question to answer, but is it, it's not just through my hands – I don't, I think it's just a sort of sense that one's developed . . . . I suppose it's the sense of . . . I guess it is a sense of health, isn't it? It's a sense of knowing deeply what health feels like . . . you kind of, you sort of know what, you know what a healthy system is" (Sarah; O2. p. 14: 592-599).

There is a sense here that we, as osteopathic practitioners – and indeed as humans – recognise health when we encounter it. Sarah (O2) goes on to explicate our ability to recognise the "expression of health" (p. 9: 394)[46] by the presence of movement and breathing in the vitality of the 'tissues' of the patient, as well as by its absence. She says,

> "it's like I ca-can see the health, I can see, I can feel vitality expressing, feel movement expressing, I can feel the restriction . . . but I don't want to dive in too quickly . . . I want to *see* whether as I tune into it whether the, whether, whether the body just with my paying *attention* can . . . . . umm . . . decompress the restriction" (Sarah; O2. p. 18: 768-774).

When asked how she might explain to a patient how cranial osteopathy works, Sarah (O2) replied in a manner that describes a process of allowing health to manifest at the same time as supporting the manifestations of unhealth.

> "Hmm . . . I suppose I would say something like, umm, I'm . . . looking to err . . . support the health, her health in her body, which is, which is *manifested* as, as *motion* and, and a kind of subtle – subtle but powerful – tissue motility and, in a sense a kind of, in a sense a kind of – breath through the tissues, or motility but areas of, of, of inertia or, or strain or dysfunction often manifest as areas of, of pain or discomfort or symptoms of some sort,

[46] The term, 'expression', used here, informs the expressivist ontological stance proposed in the current study.

> so . . . umm . . . as a practitioner if I, if I can support both the health as it manifests and, also, the, the, umm strain or, or tension or restriction patterns then it, then in some way I can find a kind of resolution of those strain patterns, through, through my supporting of her, of, of, of, of both the health but also the, the aspect that's, that's holding the inertial patterns" (Sarah; O2. pp. 16-17: 713-727).

Sarah (O2) is echoed by Graeme (O4) who recognises health by the presence of "flow", "lightness" and "floatiness" (p. 18: 781) when he encounters these aesthetic characteristics in his patients.

The osteopath participants recognise these signifiers of health and discriminate between the signs of health and those of unhealth ("inertia" (Sarah; O2. p. 17: 719), "lack of motion" (Joe; O3. p. 8: 347-348), "density" (Graeme; O4. p. 18:782), "insubstantial" (Céleste; O1. p. 5: 186).) They make intuitive, embodied judgements about the health and unhealth of their patients and their tissues, and in this way, echo Finlay (2015, p. 342) who describes her intuitive apperception of "ambivalent, sedimented meanings and texture", when she engages with her psychotherapy clients. They also echo Sheets-Johnstone (2011, p. 107), who claims that the ability to distinguish between qualities

> "is quintessential to animate life" since "all animate forms are semantically attuned to what is out there in the world . . . . colorations, patternings,

> contours, volumes, stridencies, rustlings, currents, breezes, obdurateness, limpness, moistness, scents, pungencies, bitterness, and so on".

The manner in which the cranial osteopath participants encounter such qualities in their patients – whether they are motions, motility, inertia, strain, lightness, floatiness, density or insubstantiality – as I have already shown, is with a distinctly phenomenological attitude, perhaps best conveyed by Joe (O3) in his evocative description (presented at the very end of our interview with deep hermeneutic effort) of the mode of cranial osteopathic apperception:

> "it's just such a hard thing to, to translate, isn't it? You know, it's a bit . . . it's a bit like sitting in the mist . . . you know, and every now and again the mist clears a little bit, and, you see something, and you might be – a slightly indistinct shape – and you get a sense of it – umm, and then it goes away, you know, and then you could doubt it, because it's gone away [chuckles] – umm – and then if the mist clears and the sun starts to come, you know, the, the image might get clearer – and it often feels a little bit, you know, a little bit like that – you know, certainly in the, in the initial stages" (Joe; O3. p. 36: 1593-1603).

Here, Joe (O3) is describing the enactive, embodied intersubjective process of communicating with his patient, with receptivity to the totality of the health/unhealth of the patient, which is represented in this account by "something", "slightly indistinct shape" and "image". My interpretation is that Joe (O3) is not describing the signs or signifying

features of health/unhealth, but a *Gestalt* of the being of the patient in their entirety. The metaphor of the clearing mist and the appearance of the sun is reminiscent of Heidegger's *Lichtung* ('the clearing in the forest') – which according to King (2017) and Sheehan (2014), serves as a metaphor for the source of intelligibility: "the thrown-open 'space'" (Sheehan (2014), p. 4) that is the field of potential intelligibility: a clearing that is the "always already opened-up 'space' that makes the being of things (phenomenologically: the intelligibility of things) possible and necessary" (*ibid*. p. 21).

The cranial osteopathic phenomenological apperception of the patient is followed by the unfurling expression of health. Joe (O3) describes this process in language that continues the metaphor of emergence:

> "umm – and then something begins to organise, you know, and, umm, this shape will emerge, which may or may not be confined to the body – and then, within that, things start to move – again, and that may or may not be confined to the skin – umm – you know, things start to move in the space around, or within the body . . . umm, and . . . what, what one hopes for is that towards the end of the, of the treatment, there is a quality that's more spacious . . . and where there's an easier sense of flow . . . umm . . . and where there's more of a sense of breathing, umm . . . in the voluntary sense, umm, in, in the structures you're working with, and preferably through the whole body" (Joe; O3. pp. 36-37: 1612-1627).

Through this process, health is revealed by its qualities of spaciousness, fluidity and breathing, within the patient's tissues and their "whole body" (*ibid*., 1627). The experience is echoed by the patients who, although struggling to express the ineffable, describe their experience of health in terms that indicate that it has surfaced within them, as a result of processes that are enigmatic.

6.8. Summary of the Main Findings of the Study

In the account arising from the present study, meaning is generated for the patient as their bodily senses of interoception and kinaesthesia are stimulated and produce vivid, novel aesthetic experiences that both *convey* metaphorical meaning (such as 'the feel of flowing in my legs' *means* 'some fluid is flowing in my legs') and *stand for* something meaningful ('my lymph is draining'). What appears to be happening here is that the 'background' – the somatic realm of our sense-making of the world, which is usually silent and concealed – comes uncannily to the foreground of the patient's attention and demands they shift from their natural attitude and engage in phenomenological work to unconceal the health that is always already present. The role of the cranial osteopath is to have understood the patient's symptoms through their attentive, plenisentient, bodily attunement, to have reflected their understanding back to the patient, and to have waited for the mists to clear and for health to express itself.

6.9. Discussion of Findings in the Context of Osteopathic and Related Literature

I have already indicated throughout the Discussion chapter to this point where my interpretation of the findings of my study have found echoes – and have been influenced –

by the work of other authors. I now turn to a comparison of my findings with literature that addresses the therapeutic relationship in cranial osteopathy and other CAM modalities, the neuroscience of affective touch, and the contextual therapeutic effects of healthcare.

6.9.1. Phenomenological accounts of the therapeutic relationship

As already demonstrated above, the findings of the present study have foregrounded a phenomenological account of the therapeutic relationship within cranial osteopathy, and I have already compared the findings with the embodied, enactive, 'dwelling', disclosing relationship that Finlay (2015) describes in her psychotherapeutic practice. Finlay (2015), however, does not discuss the role of touch as a therapeutic modality, meaning that there is an additional layer of experience in the cranial osteopathic relationship that bears further examination. In the Literature review chapter, I analysed four papers (Brough *et al.*, 2015; Elden, Lundgren and Robertson, 2014; Wenham *et al.*, 2018; and Whatley, Street and Kay, 2018) that aimed to examine the effectiveness of cranio-sacral therapy (CST), Alexander Technique (AT), acupuncture and reflexology. All four papers highlighted the therapeutic relationship and the enhancement of a sense of self, particularly in the domains of self-efficacy and a better sense of embodiment, but none adopted a phenomenological stance towards the lived experience of the participants. This means that the resulting analyses did not explore these features in sufficient depth to enable them to be comparators for the present study. It would have been interesting, for example, if a more explicitly interpretative analytical style had been applied to the data in the cranio-sacral therapy participant study by Elden, Lundgren and Robertson (2014, p. 3), leading to their conclusion that their

participants had “felt their bodies exhaled with relief” – a theme that emerged from the accounts of the patient participants of the current study.

The paper by Lee-Treweek (2002) examining the phenomenon of trust in the realm of complementary and alternative medicine, and which focused on the lived experience of cranial osteopathy patients, does, however, provide a useful point of reference. Lee-Treweek (2002, p. 60) made an interesting observation about the role of the cranial osteopath, from the perspective of the patients: that he was a “trained interpreter of the body’s messages and mediator between its different parts . . . . interpreter of a previously unreadable body”. This accords with one key finding of the present study, i.e., that the cranial osteopath is a hermeneut. Lee-Treweek (2002, p. 60) views the patients as contributing to a therapeutic “partnership in creating health” – in a finding that is similar to one of the themes emerging from the present study, i.e., that the cranial osteopath and the patient collaborate jointly in a hermeneutic endeavour. However, one difference between the two conclusions is that Lee-Treweek (2002) found that her patient participants were passive and detached; whereas in the present study, I have found the patient participants to be receptive (but not passive) and anything but detached – in fact, to the contrary, highly involved in their experience of cranial osteopathy, and highly reflective. The source of the difference may be two-fold. Firstly, Lee-Treweek’s study was an ethnographic one, and she interviewed successive consenting patients attending for cranial osteopathy on a single day. The present study, by contrast, has utilised a purposive sampling strategy, actively seeking to recruit patient participants who were enthusiastic about their experience of cranial osteopathy and willing to talk about it in detail and at length. Secondly, Lee-Treweek (2002)

found that the patient participants in her study did not experience aesthetic embodied experiences, whereas, in the present study, the patient participants recounted intense aesthetic embodied experiences; this difference may well have contributed to a different interpretation of the involvement of the patient participants in the therapeutic partnership, and its meaning and meaningfulness to them.

6.9.2. Neuroscience of affective touch

In the accounts of the osteopath participants in the present study, cranial osteopathic touch is an active-receptive, alive, intentful directedness towards the patient's being, the hands serving as an "interface", in the words of Céleste (O1), whose description quoted at length below animates what Stuart (2016) calls 'osteopathic manual listening':

> "I mean your hands, your *hands* are the interface; they're the thing that's connecting you to the other being, but it's your whole being that, that is involved in that conversation; and it varies from patient to patient; just like, err, a verbal conversation would. It depends who you're talking to and what mood you're both in, and, you know, what's going on, and what you're talking about, and so on. And so, sometimes, umm, . . . I will experience the symptoms that the patient is experiencing, or . . ., sometimes . . . umm . . . I will experience things that are going on in their body, umm, that they are not aware of themselves, like this lady who had the headache today, so, you know that, you know that you're not having a conversation that's at a kind of . . . umm cognitive or consciousness, err verbal level, not just verbal level;

there's, there's a lot of layers to it, because the texture of that conversation is both, umm, physiological and emotional and hormonal and biochemical, and it, and again it varies from person to person; it depends on what's going on with them" (Céleste; O1. pp. 5-6: 223-241).

If the nature of cranial osteopathy's therapeutic modality of haptic communication – as presented vividly by Céleste (O1), above – can be argued to be central to the hermeneutic model of cranial osteopathy proposed herein; and, if it is the case that the manner of cranial osteopathic touch is unparalleled by that of other modalities, then putative explanations of the role played by this distinct type of touch within the therapeutic mechanism proposed in the current study should be contextualised by contemporary understandings of the neurophysiology, philosophy, psychology and practice of touch. I have addressed some of the current literature on affective and social touch in the Literature review chapter, but find a dearth of literature that can truly account for the kind of experience conveyed by Céleste (O1) and the other osteopath participants of the current study.

There is one study, however, that has the potential to serve as a model to inform us about the capacity of light, continuous, static, attentive touch to stimulate interoceptive brain circuits, and that is the recent study by Cerritelli *et al.* (2017) introduced in the Literature review chapter. The study featured an experiment in which brain functional connectivity was measured by fMRI scans as an operator applied light, continuous, static, attentive touch to the ankles of participants (at 0.2 N). The study demonstrated statistically significant increased indicators of brain functional connectivity in the active group, compared with a

sham group. The authors conclude that, given that the neural networks detected as active during the fMRI scans – the insula and the posterior cingulate gyrus – are believed to be responsive to interoceptive stimuli, the experiment points towards a specific interoceptive role for prolonged attentive touch. They give context to this role by describing osteopathic manual techniques that they claim, "mimic the experimental study group where the operator is constantly touching the patient and contextually engaged into a focused tactile attention task, e.g. driving the attention towards the perception of myofascial movements" (Cerritelli *et al.*, 2017, p. 8).

This is an interesting hypothesis, and it might prove possible to replicate the methods of this study in a future trial that assessed prolonged, continuous osteopathic palpation in more diverse populations, and with a range of palpation pressures, a range of durations and using touch applied to various parts of the participants' body. It is very difficult to imagine, however, how it would be possible to demonstrate that what the operator perceives are "myofascial movements" and not some other aspect of the participants' expressive living body, or, indeed, their very living being, for example, in the manner of Gens and Roche (2014, p. 5[47]) who give eloquent expression to the anatomy of the patient coming to vivid

[47] "Ce qui se donne alors à percevoir est à la fois perçu avec une évidence irrécusable, et indirectement, comme à la dérobée (comme lorsqu'on appréhende l'évidence d'un symptôme sans nécessairement distinguer ce dont il est effectivement le symptôme). Et, dans le cadre de cette visualisation, l'anatomie devient vivante ou encore s'anime. Autrement dit, le ressenti se traduit et se donne à travers des images permettant une saisie et une communication avec la réalité dont elles sont comme un reflet. Ces images qui ont une force et une fonction symbolique peuvent désigner à l'ostéopathe la présence d'une distorsion ou d'une aberration d'une fonction donnée; c'est en ce sens que l'être touché se voit relayé par un « toucher » et que le traitement implique l'intervention d'une imagination créatrice."

life through the sensing touch of the 'knowing hands' of the osteopath.[48] Nonetheless, this study does give some neuroscientific grounding to the theme emerging from the current study: that haptic communication directed with attentiveness towards a patient undergoing cranial osteopathy seems to generate interoceptive awareness.

6.9.3. Contextual therapeutic effects of healthcare

In a recent paper, which I introduced in the Literature review chapter, Newell, Lothe and Raven (2017) describe a model of practice that locates the mechanism of chiropractic within the interplay between so-called "contextual effects" of care (p. 1) or "contextual factors" of care (*ibid*., p. 3) and what they call "innate healing" or "intrinsic recuperative mechanisms" (*ibid*., p. 7). The authors list some previously studied contextual factors, such as verbal and non-verbal communication within the patient-practitioner relationship; the benefit of having a clear diagnosis; a patient-centred approach; therapeutic touch; and environmental factors such as clinical architecture, setting and interior design (*ibid*., p. 7). The findings of the present study attest to the viability of the model proposed by Newell, Lothe and Raven (2017), and particularly in respect of the themes that I have identified that relate to patient help-seeking, non-verbal communication within the patient-practitioner relationship, the finding of meaning (for instance, in receiving a diagnosis), the disclosure of health (or, in the

[48] Consedine, Standen and Niven (2016).

words of Newell, Lothe and Raven (2017, p. 7), switching on “intrinsic recuperative mechanisms”), and the role of therapeutic touch.

6.9.4. Summary of discussion of study findings in the context of the literature

The findings of the present study are situated within the expressivist ontological realm of hermeneutic realism in which interpretation ‘unfolds the possibilities of being’ (Ricoeur, 2016, p. 17). They are given context by the theoretical literature on enactivist sense-making (Fuchs and de Jaegher, 2009) and embodied meaning-disclosure (Finlay, 2015). They relate to other recent qualitative literature exploring the experience of complementary and alternative therapies, differing in the way they frame the osteopathic relationship as a hermeneutic alliance that is disposed to unconceal health as it finds its expression (Lee Treweek, 2002; Brough *et al.*, 2015; Elden, Lundgren and Robertson, 2014; Wenham *et al.*, 2018; and Whatley, Street and Kay, 2018). The findings of the present study suggest that the cranial osteopathic meaning-making occurs at a prenoetic level and is afforded through the intercorporeal exchange between patient and osteopath via the medium of touch (Stuart, 2016); the findings of the study are given context by a recent study evaluating the hypothesis that attentive touch stimulates interoceptive brain circuits (Cerritelli *et al*., 2017). Finally, the study’s findings are situated within the discourse around the contextual therapeutic effects of healthcare practice (Newell, Lothe and Raven, 2017).

6.10. Critique of the Study

6.10.1. Strengths of the study

The study is an in-depth phenomenological analysis of an under-explored phenomenon – the lived experience and understanding of cranial osteopathy – that unites a praxial focus with rich idiographic testimony and a synthesis of current theory emerging across different disciplines that have not yet been examined in a doctoral-level osteopathy research project. The study has been conducted as a professional doctorate project and can claim to contribute substantially to what is known about the practice of cranial osteopathy in the UK, and additionally to have developed a new model of practice that has the potential to contribute to the discourse about the mechanisms of unorthodox therapeutic praxes.

The study has benefitted from a commitment to a phenomenological method from its genesis to its conclusion. The methodology, interpretative phenomenological analysis (IPA), was selected specifically for its suitability as a vehicle to address the research problem. The research question emerged from reflection on the phenomenological proposition of sense-making as a feature of Being-in-the-world. As researcher, I committed to an ongoing reflexivity that related my praxial experience with my unfolding understanding through the process of conducting the research, whilst developing my capacities as a phenomenological researcher and reading clinical and theoretical literature from a wide range of disciplines.

I have developed, in the course of this study, a new hermeneutic model of cranial osteopathic practice that may have a wider transferability to other complementary and alternative therapies. This has emerged from my commitment to dwelling with the process

and content of the interpretative phenomenological analysis of the accounts of my participants, along with a systematic synthesis of historical and current phenomenological thinking about embodiment, enactivist theory of action-orientated consciousness, and research into the multisensory model of perception.

6.10.2. Limitations of the study

A weakness of any qualitative investigation into the experiences of others is that its findings can never be considered transferable to other situations, contexts or populations. This particular study has a very narrow focus, and it is likely that two factors limit the wider applicability of its findings. One is the depth of involvement and interest that I, as researcher, have in the research question. I discuss this in the following paragraph. The other is that, because of the decision to recruit participants who were enthusiastic about cranial osteopathy, and who actively wished to talk to me about it, my study ignores the perspectives of osteopaths (including those who practice cranial osteopathy) and patients who have reservations about cranial osteopathy. This in itself does not limit the worth of the study, but it does limit its transferability – and therefore its potential impact.

The study, from the outset, was concerned with sense-making (about sense-making – given that, as it turns out, I have framed the cranial osteopathic encounter as a hermeneutic endeavour). It was also concerned with embodied cognition. These two factors might curry criticism that they render the research problem out of bounds for an IPA project design. For one thing, there is the problem of asking participants questions that immediately draw them into a phenomenological attitude (given that I asked them to talk to me about their sense-

making about sense-making). For another, there is the problem of the researcher being so steeped in her praxio-theoretical fore-structure that the interpretation arising from the analysis could be criticised for being a teleological prophecy fulfilled. The problem with the theme of 'attunement', which I lay out in the review of researcher reflexivity below, is a moot example. To counter these criticisms – and in an effort to mitigate their supervenience – I weighed up the arguments for sense-making as an object of phenomenological analysis and – influenced by Smith, Flowers and Larkin (2009, pp. 187-200) and Larkin, Eatough and Osborn (2011) – concluded that, with a commitment to an ongoing explication of my fore-structure and a commitment to maintaining a phenomenological reduction, IPA would be an appropriate methodology. I have tried to balance the theoretical flavour of the Findings and Discussion chapters with extensive quotations from the participants to demonstrate a care to represent their idiographic experience with fidelity. However, the theoretical focus of the project has led me to exclude a significant volume of analysed data that described the long arc of the participants' narratives in vivid and profound detail. This is a significant weakness of the study.

I had initially planned the project as a dyadic interpretative phenomenological analysis, with the intention of examining the joint meaning-making between pairs of cranial osteopaths and their patients. However, a concern to safe-guard the therapeutic boundaries had led me to interview each participant individually – rather than in their dyadic pairs. The data that emerged were rich and deep, but, unfortunately, I was not able to draw from my analysis a dyad-by-dyad account of reciprocal sense-making that I believed was trustworthy. The reasons were partly that the participants were so deeply rooted in their own accounts that

they could not shed much insight into the joint meaning-making process, and partly because I failed to ask the questions that would have generated the relevant data. I concluded that the methodology may not have been suitable to my initial aim, or that I had not effected it adequately, in this respect.

A further weakness of the study is in the method of the literature review. I had originally planned to pair the IPA study with a meta-narrative literature review (Gough, 2013) – a pluralist and cross-disciplinary approach to conducting a systematic review that takes into account different disciplinary and methodological starting-points, enabling a complex subject to be appraised and understood as fully as possible. It became apparent that it would be impossible to conduct a full meta-narrative literature review alongside an in-depth IPA within the time- and resource-constraints of a professional doctorate project, and I therefore made the decision to defer the conduct of the systematic literature review until some time in the future. The review of literature and theory at the beginning of this thesis has, therefore, not been conducted systematically, and is selective – orientated as it is around the specific concern of the research question.

A further characteristic of the study is that, having chosen to adopt a multiple hermeneutic realist ontological position and a phenomenological commitment as an osteopath-hermeneut, I made a conscious decision to avoid a constructivist epistemological gaze and therefore did not examine the ways in which the individual participants' sense-making may have been contextualised, shaped or created by wider social, cultural, political and economic factors. Of course, it is impossible to avoid being drawn into speculations about

how the individual participants' might have arrived at the thinking that they did, and this means that there will occasionally be a constructivist slant on my interpretation. In the main, however, I have avoided mixing epistemological stances. The thesis and its conclusions naturally have a particular character because of this choice, and it is clear that a constructivist approach (such as a grounded-theory research method) would have generated different data and different conclusions. It is likely that a grounded-theory analysis would have been interested in the theoretical and pedagogical influences on the thinking of the osteopaths. It had been my intention to address this question, and I did have substantial data that would have permitted me to do this, but, for logistical reasons, this was a section that I chose to omit. The conclusions I have drawn, and particularly the hermeneutic model of cranial osteopathy that I propose, should be considered in the light of my incomplete analysis of all of the data that it would have been possible to analyse.

Another weakness of the study is my failure to fully compare its findings with the theoretical foundations of – and current research into – therapeutic modalities related to psychology, psychotherapy and counselling. I have made reference to person-centred counselling, relational integrative psychotherapy and body psychotherapy, but I have not turned to Freudian, Jungian, existentialist or cognitive-behavioural approaches. It is likely that the findings would have been influenced – and possibly even altered significantly – if I had become more knowledgeable about these psychotherapeutic traditions, and particularly their way of framing the therapeutic relationship.

In a similar vein, I did not conduct any formal or informal research or undertake any training in biodynamic osteopathy, a tradition that has evolved since the 1980s from the Sutherland model of which I have experience. I made this decision deliberately, given that my aim was to study sense-making about the phenomenon of cranial osteopathy in which I am trained (so that I would be able to adopt an insider's perspective). But I have a sense that some of the concepts and themes that have emerged from this study owe to the traditions and language of the biodynamic approach, and it is likely that I will find out more about this unacknowledged background influence on the proposed hermeneutic model of cranial osteopathy when I begin to discuss it with my colleagues.

6.11. Review of Researcher Reflexivity

As set out in the Methodology chapter, I kept ongoing track of the influences on my thinking in order to reflect and to 'slacken the intentional threads' (Merleau-Ponty, 1962, p. xv) that anchor me in my world. This I did so that I could account for my fore-structure, which I broke down into the Heideggerian *Vorhabe*, *Vorsicht*, *Vorgriff* triad, as interpreted by Dreyfus (1980). I remained aware that the drive to answer the research question was a personal and praxial one, and that I would be searching for any theoretical or evidentiary platform that could support my evolving understanding. I therefore did not undertake this research project in a spirit of equipoise; I undertook it searchingly, consumingly, thoughtfully – at all times holding in mind the inter-related interests of my roles as professional, clinician, researcher, educator and person. I debated long and hard the problem of IPA's position on theory, and made the decision to adapt the methodology for the purposes of the research question. Since the research problem arose from thinking

about theory, it would be impossible to abjure a meta-theoretical perspective (see Appendix 26 for a mind-map of my hermeneutic fore-structure). Since the research question posed the challenge to make sense of sense-making, it would be nonsensical to reject a triple, or even multiple, hermeneutic position on sense-making about sense-making about sense-making. My commitment, then, was to be as accountable as it is possible to be in acknowledging the influences on my hermeneutic engagement in this IPA study, whilst remaining in the phenomenological attitude with respect to the accounts my participants gave of their lived experience.

I have maintained a reflexive diary that incorporates insights from practice, reading, conversations, conferences and discussions with colleagues and my supervisory team, from the initial conception of the study. I have repeated reflexive exercises about my stance and beliefs at regular exercises, particularly in the lead-up to and in between the interviews with the participants. I had numerous discussions with my Director of Studies about my preconceptions, particularly around the time of undergoing an audio-recorded interview in which he put to me the questions that I went on to put to my participants.

Although it would be possible, it would be overly completist to provide as an appendix all of the raw data that constitutes my reflexive account. Instead, I select some examples below that shed light on the conclusions I went on to draw whilst undertaking the hermeneutic analysis of the accounts of the study's participants.

6.11.1. The concept of 'attunement'

Here, I consider the genealogy of my use of the concept of 'attunement' in respect of the cranial osteopathic therapeutic relationship.

- "I have the sense that it is possible to palpate the vibrations that travel through human tissue from physiological activity within the living body. I believe that it is possible to detect the sense of pressure change within the cranium – particularly at certain sutures in certain skulls – and I find it amazing that this is controversial – and wonder at how detached we have become from our very basic, mammalian capabilities – but I put that down to the phenomenon of the divided brain and the oculocentrism of our current times. And I do think that there is something that occurs when the two beings collaborate with the intention to support the physiological processes that underlie health. There may be an entrainment of the central nervous systems of the two individuals – an attunement that perhaps could be measured by an instrument that measures Hz to a very fine degree. That entrainment could be occurring simultaneously in the psychological and the physical domains mediated by the CNS".

(Reflexive Journal, 23 August 2017).

In this entry, I ruminate on the physiological capacity of humans to palpate vibrations that emanate from biological processes within the living body. I am thinking of the ability to palpate pulses, for example, but also some finer currents of electrical activity. I am postulating that it may be possible to palpate the electrical tone of contracted muscles or of

neural activity. I am declaring a belief that it must be possible to palpate pressure changes within another person's cranium, despite reading convincing evidence to the contrary (e.g. Gabutti and Draper-Rodi, 2014).

From this point, I move towards a speculation about the mechanistic potency of therapeutic collaboration, and reflect on the notion of 'entrainment', which I remember having discussed with an osteopathic colleague of mine, who told me about the way that psychologists help people struggling with anxiety by breathing slowly and waiting for their clients to fall in with their respiratory rhythm. These ideas are in dialogue with the hermeneutic analysis I have undertaken nine months later, and can be seen to take form in patient sub-theme 2.4. 'attunement metaphor', osteopathic sub-theme 1.2. '*Gestalt* perception', osteopath sub-theme 2.1. 'intersubjective resonance', osteopath sub-theme 3.2. 'haptic hermeneusis' and osteopath sub-theme 3.3. 'embodying empathy'. They also inform my discussion of Super-Ordinate Theme 2, above.

Later still, when writing the Literature review chapter, I recall that Svenaeus (2000b, p. 179), in his account of the hermeneutic relationship between the doctor and the patient uses the term, 'attunement' to describe how "an intense and often dramatic form of attunement" arises in a clinical encounter. I acknowledge how reading this paper, which I did in 2014, must have influenced my thinking. Yet the source for this concept of attunement lies even further in the past than that. I return to the notes I made when reading McKone (2001) in 2002, prior to beginning my osteopathic training. My very first insight into the mechanism of osteopathy was that it was generated through the action of the therapeutic relationship:

"the osteopath participates in the healing of a patient, by attuning to the internally self-organizing system of the mind-body, and not by directing it" (Banton, 2002; see Appendix 1).

6.11.2. The concept of embodied metaphor

> "When working in my clinic, had an insight into how our body's concepts are to do with survival – e.g. we know in our bodies what nurture feels like (e.g. "smoothing out"). We know what our "midline axis" is – of course – because we are bipedal beings in a world of UP/DOWN where gravity influences us. I think there is a metaphorical structure where these abstract concepts are felt in the body, operationalised through biochemistry, and then translated across to the reflective mind".
>
> (Reflexive Journal, 25 May 2018).

This reflection came to me after reading Lakoff and Johnson (1980), when I began to grasp the concept of embodied cognitive linguistics. I had already come to understand from reading Gallagher (2017) and Sheets-Johnstone (2011) that it is possible to conceive of the bodies of creatures with animate forms (including those of we humans) as having embodied consciousness that is capable of prenoetic conceptualisation, symbolism and even representationalism that remains at an unverbal level. The journal entry demonstrates how I spontaneously embedded these insights into my clinical praxis, and, thence, into my hermeneutic analysis. The reference to "smoothing out" relates to Eva's (P2) description of

her pains being all smoothed out by treatment. The reference to UP/DOWN I went on to relate to the cases of both Richard (P1) and Joanna (P3).

6.12. Chapter Summary

In this chapter, I have discussed the meaning of the three Super-Ordinate Themes to have emerged from the study: 1) Making sense of sense-making, 2) Metaphors for mechanisms, and 3) The meaningful osteopathic relationship. I show how my interpretative, phenomenological analysis of the accounts of the participants has led to the evolution of a novel theory of practice that makes sense of the phenomenon of cranial osteopathy – the hermeneutic model of cranial osteopathy, which involves prenoetic, embodied sense-making and meaning-disclosure, and which aims to unconceal health that is always already there. I consider this model in the context of phenomenological, enactivist and osteopathic theoretical traditions and evidence, then go on to critique the strengths and limitations of the study. I conclude with a review of my reflexivity as a researcher, and give examples of how I worked with my fore-structure in order to maintain an attitude of phenomenological reduction.

CHAPTER 7: CONCLUSION

7.1. Introduction

The imperative to undertake this study arose from praxial origins: the struggle I faced on a daily basis to answer the questions of my patients about the mechanism of cranial osteopathy, i.e. how it might be said to 'work'. The study has not provided me with an answer to this question, but it has furnished a model that could be used, discussed and explored in further studies that might go on to shed further light on the enigmatic phenomenon at the heart of cranial osteopathy.

The study has enabled me to embed the lived experience of the patient and osteopath participants within a hermeneutic tradition that spans the thinking of Heidegger, Marion, Gadamer and Svenaeus and which can be considered to accord with the osteopathic dictum that it should be the object of the osteopath "to find health" (Stark, 2012, p. 371) in their patient, a version of osteopathy which McKone (2001, p. vii) describes as "a continual coming into knowing", which O'Brien (2013, p. 112) describes as "an opening-up experience", and which Becker (1997, p. 51) describes as a way of working "to manifest health".

The study has also explored phenomenological and enactivist models of embodied meaning-disclosure (Gendlin, 1962; Finlay, 2015) that provide an explanatory framework for the prenoetic aesthetic experience of patients and practitioners of cranial osteopathy. I have demonstrated how it is possible to frame the embodied sense-making of cranial osteopaths

and their patients as the operation of metaphorical cognition (Lakoff and Johnson, 1980a, 1980b; Finlay 2015), and have proposed that the articulation of such metaphorical cognition takes the form of meta-metaphorical language (whether vocalised or not). Gendlin (1962, p. 19) proposed that "[t]here is no necessity that language kill experiencing", and I have demonstrated that, with committed phenomenological work, patients and practitioners of cranial osteopathy are able to make sense of the phenomenon of cranial osteopathy through the expression of seemingly ineffable aesthetic, embodied experiences (for which it had hitherto been thought that the words were lacking).

7.2. Implications of the Study for Osteopathic and Other Healthcare Research

The genesis of this study lay in the dissonance I identified in the way I talked to my patients about the mechanism of cranial osteopathy – or, more to the point, the way I avoided talking to them about it. I had not been able to evolve a working model that would make sense to patients and cohere with my existing knowledge of physiology and psychology, whilst at the same time standing up to external scrutiny. The last point I take seriously: as a member of a regulated profession, it is important that I am able demonstrate my answerability to critics (from both within the profession and without) who challenge me to explain how cranial osteopathy can be said to work.

After several years researching the problem, supervising osteopathy master's dissertations and running evidence-based practice modules, I came to agree with the Kuhnian position that the questions that remain unanswered within the epistemological framework of either past or contemporary paradigms require answers that can only emerge within new

paradigms. Osteopathic knowledge was once legitimate, when it emerged within the empirical and pragmatist paradigm of turn of twentieth-century USA frontier medicine, but, as I have shown, it has questionable legitimacy in the eyes of turn of the twenty-first century evidence-based medicine (EBM). One of the problems I identified is that the plausibility of the mechanism of cranial osteopathy is so contested that it is difficult to abstract and condense it both *meaningfully* (to its proponents) and *convincingly* (to its detractors) so that it will fit in the mechanistic black box of the EBM clinical trial format. This means that EBM clinical trials of cranial osteopathy are bound, from the offset, to measure invalid outcomes unreliably.

There is hope, however, that the 'renaissance' of EBM (Greenhalgh, Howick and Maskrey, 2014; Greenhalgh *et al.*, 2015; Kelly *et al.*, 2015), which makes an argument for re-evaluating and re-contextualising the philosophical concerns of ontology (Tyreman, 2018b), causation (Kerry *et al.*, 2012) and mechanisms (Wieten, 2018), may influence the evolution of EBM so that it can accommodate a warranted examination of the experience and meaningfulness as well as of the effectiveness of complex, contested complementary and alternative healthcare practices, such as cranial osteopathy. The renaissance requires an ontological and epistemological shift, so that new-paradigm EBM is capable of incorporating the realms of tacit knowledge, professional phronesis and practice-based wisdom as operative within clinical 'interventions' – and these in addition to the contextual effects of therapy examined by Newell, Lothe and Raven (2017).

I argue that the new-paradigm EBM should take an onto-epistemological shift away from objectivism towards a plural, hermeneutic realist stance that permits multiple expressions of the phenomenon of cranial osteopathy, and – as in the focus of the present study – the central role of the intersubjective, enactive, hermeneutic therapeutic relationship. As I have demonstrated in this thesis, from the hermeneutic realist stance, the adjacent facets of the phenomenon of cranial osteopathy reflect different explicatory expressions, amongst them, the neurophysiological, the psychological and the existential. The current study points to the co-extensive, co-existent multiple realities of the complex ontology of cranial osteopathy, and I argue that EBM should be open to this account of clinical interventions that are poorly understood, from a positivist perspective. I also suggest that the concept of an outcome measure (e.g. a pain scale or an index of function) should be revisited so that it is capable of including outcomes that account for what patient participants themselves decide are meaningful.

Future studies could shed further light on the complexity and meaningfulness of the lived experience of cranial osteopathy, using methodologies that, rooted in plural realism, permit a multidisciplinary analysis. In particular, there could be a far deeper connection across the theoretical base and forms of practice that currently separate psychology (and its related disciplines) and osteopathy (and other physical therapies). Methods could include the meta-narrative review, ethnographic approaches and well-designed mixed-methods intervention studies that avoid the fallacy of placing the question of the mechanism out of play and into a black box, which, as I have argued, leads to the reductive measurement of proxy outcomes

(i.e. pain and function scores) when what is at issue for the patient is something specific and meaningful to them.

It may also be of value to consider the model of healthcare as a health-disclosing hermeneutic endeavour in other physical therapy contexts, particularly those that involve haptic communication. It might be of interest to explore whether the non-discursive living-body to living-body receptive communication utilised by cranial osteopaths described herein is also utilised in other healthcare contexts. IPA, or other phenomenological methodologies, could be used to examine the lived experience of practitioners and patients of chiropractic, physiotherapy, Shiatsu, reflexology and Reiki, for example.

What I have not uncovered in the conduct of this research project is any argument to support the Sutherland model of cranial osteopathy as a system that, on the surface, bears much examination as an anatomico-physiological construct according to the discourse of twenty-first century science. It should be emphasised that it was not my aim to examine the validity of the construct; indeed, I would have utilised a different study design, had it been my goal. Had I recruited different osteopath participants, or a greater number, or a more heterogeneous population, it is possible that I might have encountered strong and convincing defences of, and arguments for, the Sutherland model as something more than a metaphor, a framework, a teaching device or a starting point on the subtle, aesthetic and empathic journey undertaken by cranial osteopaths as they learn to be effective practitioners. Some kind of comparative study, exploring what is unique and what is common in the experience and understanding of populations of cranial osteopaths (and

their patients) and other types of complementary or alternative healthcare practitioner would be warranted.

Given the methodological frailty of the current study in examining with precision and fidelity the dyadic relationship between patients and practitioners, it would certainly be of value to explore methodologies that could capture the process and content of the mutual therapeutic sense-making purported to exist in this Discussion chapter. These methods could include audio- or video-recordings of therapeutic encounters and written accounts of the experience before and after the treatment. There would be ethical challenges to overcome, undoubtedly, and questions as to the performative and presentational drivers for both patient and practitioner participants. Nonetheless, this kind of study would have both pertinence and novelty in respect of the question of what actually *appears* to happen in the course of a therapeutic encounter.

The present study has, however, demonstrated that it is possible to use IPA to examine the phenomenological stance of participants as they make sense of not only the overt events of their lived experience, but also of their conceptions about their sense-making, at levels that are both reflective and prenoetic. IPA could be used in the manner of this study to analyse the experience of a series of case studies, so that it would be possible to illuminate the idiographic experience of individuals (patients, practitioners, educators, policy-makers, researchers – whether in the field of osteopathy, cranial osteopathy, or any other fractal of medicine or healthcare practice), to demonstrate the singularity of what is meaningful to

each person in their Lifeworld. In this way, it would be possible to create a rich and 360° picture of praxis.

7.3. Implications of the Study for Osteopathic Practice

As a result of the study, my personal practice has changed. I am now able to make better sense of the phenomenon of cranial osteopathy, and to give an account of its mechanism that is based on the account I have developed through the conduct of this research project. After peer-review, validity-testing and refining the hermeneutic model of cranial osteopathy, I may be able to tell patients that, during the course of a cranial osteopathic encounter (or series of encounters), I use my skills of embodied empathy to detect indications of their distress that might not arise to their overt consciousness, and give them the time and space to resolve; that I use my haptic contact and haptic consciousness to communicate comfort and calm, to this end. I may be able to say that I understand cranial osteopathic practice has its origins in the evolutionary traits of affective and social touch. I may be able to say that symptoms, and my reading of them, may or may not be relevant to their experience of health or unhealth, and that what seems relevant to me today may not register as relevant tomorrow – and also that a different practitioner may see and sense very different signs. I may be able to say that I am working on the basis that the tendency towards health is better expressed when factors that interfere with homeostatic function are mitigated – for example, by attention towards interoceptive signals, a sense of embodiment and by a different manner of breathing.

I would also need to own that this account is partial, inadequate and highly metaphorical – a manner of speaking that may make sense to them, or may not. I would have to admit that it is very unlikely that the phenomenon of cranial osteopathy will ever be capable of articulation, in the same way that so many realms of prenoetic experience fail to find adequate expression in words – but that this should not prevent us from trying to understand and explain the profundity and richness of our lived experience.

The findings of this study may be capable of extending a greater reach than the limited purview of my own personal practice. I hope to find a way of communicating its findings to fellow osteopaths, to other healthcare practitioners and to philosophers of healthcare and medicine who are interested in the experience and the ontology of health. The beginning of this process is to advocate an onto-epistemological stance that accommodates a plural, expressivist ontology and an interpretivist epistemology. Next is to frame healthcare as an intersubjective hermeneutic project, and healthcare that involves haptic communication as a reciprocally aesthetic, embodied and health-disclosing endeavour. The central concept has two aspects: the first is that the *very process* of embodied sense-making provides relief to the help-seeker; the second is that the *meaningful content* that emerges from the aesthetic engagement fulfils needs in the help-seeker that are both unique and universal.

7.4. Thesis Conclusion

This study is an interpretative phenomenological analysis of the sense-making of four cranial osteopaths and a patient of each of theirs about the phenomenon of cranial osteopathy. The IPA revealed that both patients and practitioners establish epistemological grounds for

their sense-making about their embodied experience of cranial osteopathy (Super-Ordinate Theme 1: Making sense of sense-making), that they use embodied metaphor and linguistic meta-metaphor to understand their lived experience of cranial osteopathy (Super-Ordinate Theme 2: Metaphors for mechanisms), and that the mechanism of cranial osteopathy is considered by both patients and practitioners to arise from the therapeutic relationship (Super-Ordinate Theme 3: The meaningful osteopathic relationship).

The main outcome of this study is a hermeneutic model of cranial osteopathy which posits that the shared, embodied therapeutic relationship is the site of an empathetic communication that "founds transitivity from one body to another" (Merleau-Ponty, 1968, p. 143) and which facilitates – through a collaborative rapport, in which the osteopath dwells with their patient – an embodied attunement which provides the relief that comes from having insight into the source of a problem and which allows health – which is always already there – to be unconcealed.

A final word on language: it is an exquisite challenge to be writing about sense-making of an elusive phenomenon whilst using philosophical language that is complex and open to interpretation, originating – as it does – in the writing of continental philosophers famous for their expressive yet – at times – impenetrable neologistic prose. The glossary, at Appendix 27, contains some working definitions of terms I use often in the thesis. I have provided a rationale for my definitions, whilst recognising that other meanings are equally justified.

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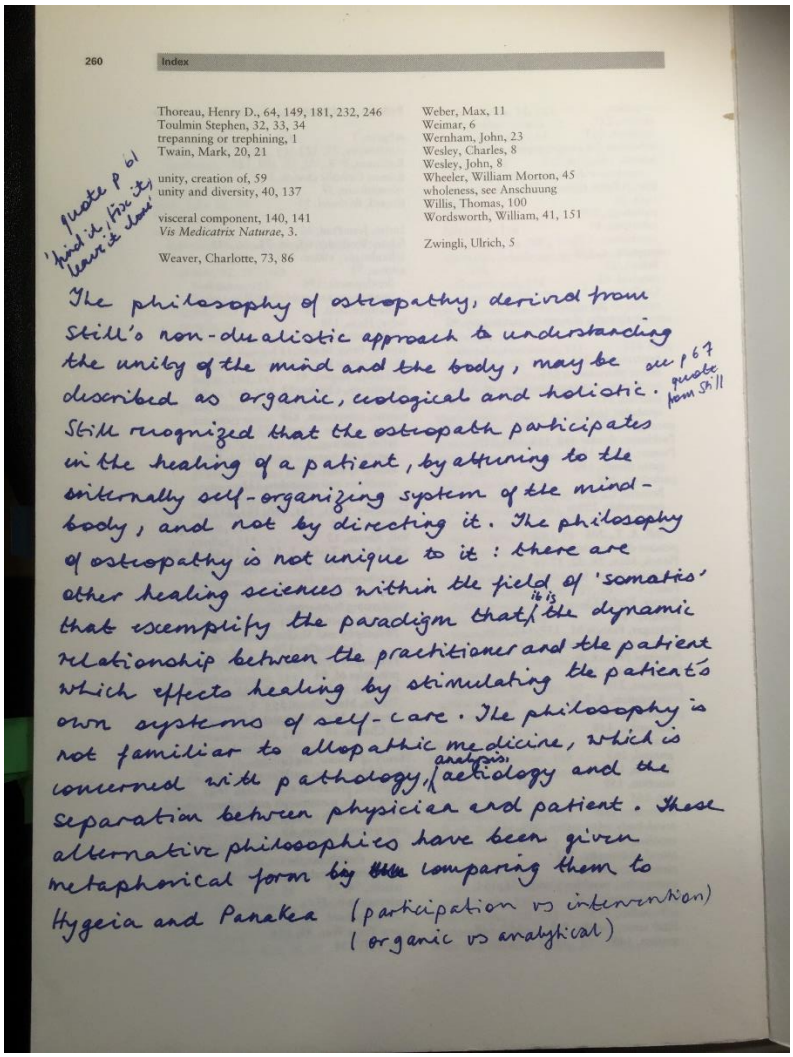
APPENDICES

APPENDIX 1 RESEARCHER'S EARLY THOUGHTS ON OSTEOPATHY (2002)



quote p 61 'find it, fix it, leave it' Still

The philosophy of osteopathy, derived from Still's non-dualistic approach to understanding the unity of the mind and the body, may be described as organic, ecological and holistic. see p 67 quote from Still Still recognized that the osteopath participates in the healing of a patient, by attuning to the internally self-organizing system of the mind-body, and not by directing it. The philosophy of osteopathy is not unique to it: there are other healing sciences within the field of 'somatics' that exemplify the paradigm that is the dynamic relationship between the practitioner and the patient which effects healing by stimulating the patient's own systems of self-care. The philosophy is not familiar to allopathic medicine, which is concerned with pathology, (anatomy) aetiology and the separation between physician and patient. These alternative philosophies have been given metaphorical form by ~~Hill~~ comparing them to Hygeia and Panakea (participation vs intervention) (organic vs analytical)

APPENDIX 2 IPA TRAINING SESSIONS ATTENDED

16th-17th May 2015	London	**Introduction to IPA** Dr Elena Gil Rodriquez Dr Kate Hefferon
1st July 2015	Glasgow Caledonian University	**Introduction to IPA** Prof Paul Flowers
1st March 2016	Northumbria University	**IPA lunchtime seminar**
12th October 2016	Derby University	**IPA Interviews** Dr Fiona Holland
29th March 2017	Derby University	**IPA Data Analysis** Dr Fiona Holland
3rd January 2018	Glasgow Caledonian University	**Hermeneutic theory in IPA** Dr Virginia Eatough
25th April 2018	Glasgow Caledonian University	**IPA Data Analysis** Prof Jonathan Smith
23rd May 2018	Glasgow Caledonian University	**IPA Data Analysis** Prof Paul Flowers

APPENDIX 3 DETAILED NOTES ON DATA ANALYSIS PROCESS

STAGES OF ANALYSIS	METHOD & REFERENCES	NOTES & QUERIES
Transcript approved by participant, with minor emendations	Minor emendations incorporated Transcript converted to IPA template within MS Word Document. See Smith, Flowers and Larkin (2009) Box 5.1 (pp. 85-87) and Box 5.2 (pp. 93-95).	**Coding Process Legend** Hermeneutic Fore-Structure elaborated within MS Word Review Function [comments bubbles in right margin] Content Description in blue in right column *Linguistic Analysis italicised in green in right column* Conceptual analysis underlined in purple in right column Hermeneutic Analysis in red in left column **Initial themes in bold red in left column**
Level 1 – Elaboration of Hermeneutic Fore-structure	"Free textual analysis" (Smith, Flowers and Larkin, 2009, p. 83) conducted by researcher, elaborating her hermeneutic fore-structure through an auto-dialogic process inspired by Johns (2013) Process included reflection on and clarification of position on epistemology, understanding of theory, empathy with praxial concerns, suspicion of some aspects of professional judgement. Reflexive stance as recommended by Merleau-Ponty (1962, p. xv): Reflection "steps back to watch the forms of transcendence fly up like sparks from a fire; it slackens the intentional threads which attach us to the world and thus brings them to our notice".	Fore-structure discussed with Director of Studies Ongoing dialogue between researcher and Director of Studies recorded in e-mail conversations
Level 2 – Content Description	Line-by-line description of transcript content (See thesis log 03/11/17 for details).	Lengthy process, possibly over-elaborated, with concerns over expressing voice of participant inhibiting the analysis researcher troubled by the tense used in describing reported speech and action and also reflections on thoughts about reported speech and action. researcher chose to use perfect tense for speech and action reported, and pluperfect tense for reflections on speech and action reported.

Level 3 – Linguistic Analysis Level 4 – Conceptual Analysis	Initial plan was to conduct these two stages serially, but after experimentation it became clear that it was necessary to conduct them in parallel – this was in order to judge when an observation was primarily linguistic or conceptual, as there was often over-lapping between these two strands of analysis. <u>Linguistic Analysis</u> Discussion about method of linguistic analysis between researcher and Director of Studies. Research into this and position statement (See thesis log 03/11/17). Smith, Flowers and Larkin (2009, p. 88) suggest noting pronoun use, pauses, laughter, functional aspects of language, repetition, tone, degree of fluency and metaphor. This is the approach that chosen. <u>Conceptual Analysis</u> Conceptual coding was undertaking by examining the transcript for text that appeared to have significance for the participant, through the hermeneutic lens of the researcher, who identified both the existence and the content of the significant text through continual reference to her own hermeneutic fore-structure. "Significance to the participant" was judged by examining sections of text in the context of the whole, by consideration of the linguistic functions employed, and by identification with the hermeneutic process of the participant.	<u>Linguistic Analysis</u> The working basis for linguistic analysis eventually informed by enactive and embodied theories of language informed by Lakoff and Johnson (1980a and b) – that is, that language has evolved to enable humans to communicate about their embodied interaction with the environment. Language is basically a set of metaphorical structures that explains our phenomenological engagement in a world of meaning, which specifically has meaning related to our embodied "thrownness" into the world. Also informed by Charles Taylor (2016) The Language Animal. <u>Conceptual Analysis</u> The process of conceptual analysis threw up the unresolved problem of the multiple hermeneutic. See thesis log 14/11/17: "I can count six enfolding layers of hermeneusis – and it put me in mind of Matryoshka dolls – that nest within each other – so: Osteopath interprets Researcher, interpreting Participant, interpreting Patient, interpreting Phenomenon of how they interpret Cranial Osteopathy".
Level 5 – Hermeneutic Analysis	The hermeneutic analysis involved a distillation of the combined content/linguistic/conceptual analysis. The emerging initial themes were filtered through the researcher's hermeneutic fore-structure, i.e. they surfaced in the medium of the researcher's ever-developing understanding of the subject of sense-making about the lived experience of cranial osteopathy.	The process of distillation meant that some sections of the text were filtered out, on the grounds that they had too little connection with the research question. The adjudication of whether to include or exclude a code was undertaken with deliberation, and in the end rested with the researcher, after discussion with the Director of Studies.

Level 6 – Initial Emergent Themes	The initial themes "emerged" from the Level 5 process described above. The emergence of the initial themes occurred as the researcher considered their significance, with reference to her hermeneutic fore-structure and the research question. This process required a phenomenological state of consciousness, which required neither complete concentration on the literal meaning of the words, nor too diffuse an engagement with the meaning of the whole text. The initial themes were recorded in a table, and illustrated by quotations from the transcript. The table was developed in chronological sequence, meaning that similar themes emerged on different occasions, as certain topics or expressions arose subsequently. The researcher added hermeneutic notes, and, in a separate column, added brief notes about related theory. The aim was not to explicate the themes with reference to the theory at this stage. The notes were brief, and were included in order to provide an audit trail of the Researcher's theoretical fore-structure.	Prior to beginning the data-analysis, the researcher invested effort into understanding the process whereby themes in qualitative research are said, on the one hand, to emerge, and, on the other, to be constructed; see reflexive journal 31/10/17. On 18/01/18, I concluded: "I have been thinking about whether themes "emerge", and after having previously rationalised a rejection of "construction" and chosen "development" instead, I find the present participle, "developing", does not capture the intentionality of the theme in its manner of its appearance to my consciousness. In the spirit of phenomenology, I have re-considered and am going to use the phrase "emergent themes". In the Etymology Online Dictionary, "Emergent" – 1560s, from Middle French émerger and directly from Latin emergere "bring forth, bring to light", intransitively "arise out or up, come forth, come up, come out, rise", from assimilated form of ex "out" (see **ex-**) + mergere "to dip, sink" (see **merge**). The notion is of rising from a liquid by virtue of buoyancy. Related: Emerged; emerging. This is consistent with Smith, Flowers and Larkin (2009), p. 91.
Level 7 – Sorting and Clustering of Initial Themes into Categories	The table of initial themes, quotations and brief notes was printed, then cut with scissors into strips. The initial themes were sorted in a manual/mental (i.e. embodied) clustering exercise to form categories. This was initially done swiftly and intuitively, with the paper strips placed in a two-dimensional spatial "map" on the floor, with a small number of themes left on a separate "too-hard pile". The process was then given closer inspection, and initial themes were double-checked for their relatedness. Several initial themes changed position, and several clusters of initial themes were shifted to be closer together or further apart according to their	

	conceptual relatedness to each other (e.g. "beneficial outcomes" and "side-effects" were placed side-by-side, below "experience of cranial osteopathy"). The result approximated a physical mind-map.	
Level 8 – Sorting of Categories	The Level 7 sorting and clustering process had made apparent a hierarchy of categories, in which, as cited above, the researcher adjudged that "beneficial outcomes" and "side-effects" "belonged with" the overarching category of "experience of cranial osteopathy". This process required working through with mind-mapping software (Espresso Mind Map initially, and then LucidChart). There was a process of repeated adjudication whether initial themes "belonged with" one another, and, if so, whether in a super-ordinate or sub-ordinate relation. This process required both "abstraction" and "subsumption", described in the adjacent column.	Abstraction describes a "basic form of identifying patterns between emergent themes and developing a sense of what can be called a 'super-ordinate' theme" (Smith, Flowers and Larkin, 2009, p. 96. An example would be identifying "experience of cranial osteopathy" as an over-arching category. Subsumption describes the process whereby certain themes are adjudged to "belong under" the super-ordinate theme (Smith, Flowers and Larkin, 2009, p. 97). An example would be identifying "beneficial outcomes" and "side-effects" as related to, but sub-ordinate to, "experience of cranial osteopathy". Audited by Director of Studies.
Level 9 – Elaboration of Emergent Themes	The next stage involved a re-sorting exercise, allowing themes to emerge from the categorisation of initial themes describe in Level 7 and 8. The initial themes and categories were cut into strips and sorted in a mental/manual exercise on the floor. As a result of this process, new relationships were conceived between certain initial themes, and certain categories were brought together. The aim was to allow the emergence of the themes that represented the lived experience/understanding of the participants with the greatest fidelity, with respect to the project's research question.	Audited by Director of Studies.
Level 10 – Audit of Transcript	Whole transcript audited to ensure that the process of analysis has constructed a trustworthy *Gestalt* from the data.	Undertaken by Director of Studies and researcher.

Saturday 25th November 2017

1. Non-verbal communication between osteopath and patient – its ontic and ontological properties.

All week, it's been going through my head that I am struggling to understand what the difference is between the modes of sensory perception and judgement that are used by osteopaths practising (let's call it) "structural osteopathy" and those used by cranial osteopaths. It follows on from my ruminations of 19th November (above). And in the end, I wondered if it came down to the idea that with both structural and cranial osteopathy the problem is with the idea that the content of what is perceived is inherently meaningful. I think about the diagnostic validity studies that suggest the sensory perception of osteopaths repeatedly fails to identify or measure what it is intended to identify and measure (e.g. cranial rhythmic impulse palpation studies; palpatory identification of specific vertebrae; observable postural findings), nor is there intra-rater or inter-rater reliability in these studies.

I accept these studies. What I perceive has meaning to me, but I must accept that it is a partial, subjective and "projected" process of perception, whose meaning originates in my expectations and is fulfilled by the "gap-filling" I do to enable my expectations about the world to be re-inforced. I do this will my whole sensory apparatus. I do this by making short-hand judgements about the visible physical, postural signs I identify in antalgic patients. I do

this in the same way with the palpatory percepts I identify with my haptic senses. It is how I hear the meaning of a person on the telephone, even if I do not hear every second word they say because of a patchy network. Or how I taste lemon when I see or lick a citric yellow sorbet (actually, I don't think my olfactory or gustatory senses are quite as partial as my visual, auditory and haptic senses; possibly because of the different evolutionary pathways of the neurology of the different senses?)

So, the process of my sensory perception is underpinned by my fore-structures; the content of what I perceive is similarly constructed by my expectations. I can persuade any person working with me (e.g. another osteopath, a patient, or a chaperone) that the process and content of my perceptions are meaningful (and that the meaning I have made has a relationship with the thing I have perceived, aka the intentional object, aka the phenomenon). This does not require manipulation, or a con-trick. I have no malign intentions – in fact, of course, my intentions are to do no harm at all. People working with me have faith that my observations are valid, significant and reliable. My judgements become part of their fore-structure, because we are co-working, and I am the expert.

Does that mean that osteopaths should not use their sensory apparatus in helping their patients? Should our practice be changed so that we (only) work with data (the history), dialogue (the consultation) and personalised life-style plans, involving the best available evidence? And if we do incorporate manual therapy, it should be generalised and formulaic, technical, rather than interpretative? Possibly.

But I have had another thought and that it is that the important work of the sensory inter-change between patient and practitioner may not be about either the process or the content of perception – but it might be to do with the ontic nature of the sensory interchange (i.e. the fact of it) and also the quality of it. Two people look at each other. They do so with respectful, compassionate (but not transgressive) eye contact. The interchange is both active and receptive, for both. The fact of the interaction and its quality initiate a change for both. Two people are in physical contact with each other. The touch is respectful and compassionate (but not transgressive). The fact of the interaction and its quality initiate a change for both. Meaning-making occurs with both types of non-verbal communication – but the meaning that is constructed might be an epiphenomenon, a sort of mental light-show that gives us a sense of insight and understanding – but that is actually a by-product of the process of interacting with our sensory apparatus.

2. My revelation about the actual research question (i.e. what sense do I make of the lived experience of cranial osteopathy) and my understanding of the purpose of being able to describe and analyse my fore-structure.

I realised that I have abstracted my own research question into a project to analyse the third-person (singular and plural) perspective on my intentional object (the ontology of my professional praxis).

Would it have been advisable to use a different methodology, something auto-ethnographic or to do with reflective practice to have tackled my subject?

I think I have to stay with phenomenological analysis (for the time-being?) – but somehow I feel inauthentic persisting with a research question and method that I'm using as a smoke-screen for my real investigations.

If I stay with IPA, I will use this data as evidence of coming to understand my hermeneutic fore-structure.

MMP says the philosopher/scientist "must suspend the affirmations which are implied in the given facts of his life. But to suspend them is not to deny them and even less to deny the link which binds us to the physical, social and cultural world. It is on the contrary to see this link, to become conscious of it". (Drew, Dahlberg and Nyström, 2001).

My fore-structure is my set of spectacles that afford me my particular perspective on my world. I always bear in mind that my interpretation is bound up in my world-view, whilst also acknowledging that it is possible to adopt other world-views (and of course for one's own world-view to develop).

Acknowledging my fore-structure might entail an ongoing commentary on my personal and professional contexts, and how they afford me the interpretations at which I arrive.

Tuesday 6th February 2018

Just a bit of reflection – in my practice recently, I really began to understand that osteopathy is a life-world project. It is, in some ways, as though you are in receptive mode,

attuned to your patient's spoken and un-spoken needs, and you are undergoing a very fast calibration to understand the best way to help them – there is the medical triage, the body language appraisal, a tuning in on an empathic level, and an intuition about what they are really telling you about the significance to them of their symptoms. This multiple-layered hermeneusis can help you to hone in on the meaningful aspects of their presentation – and what is meaningful to you might not be so to them – you may have to win them over so that you can put your mind at ease about any pathological significance in their history. This involves a fast and subtle negotiation – perhaps we ***are*** like people who negotiate with hostage-takers! All along, you are showing that you can help them make sense of their symptoms – there is the promise of that when all the assessment is done. When you have worked out what is of utmost importance today – reassurance, explanation, action, a plan, treatment (hands-on or otherwise) – you can work towards that, sign-posting throughout that you will get to that by the end of the session. You are ***for*** your patient, you are ***with*** your patient, you are attuned ***to*** your patient, and you accompany them so that your horizons of understanding merge and you can be with them together in the world.

Thursday 8th February 2018

I was thinking more about the quality of being with a patient. For such a long time I have been trying to identify the ontological basis of the meaningful rapport between a patient and a (health-care) practitioner – and I have come to recognise that "enactive inter-subjective encounter" describes it but I don't like this phrase. "Inter-subjective encounter" perhaps covers it, and "Horizontverschmelzung" does too – but none of these trip off the

tongue! I was then thinking of “mitsein” – and that really does express it so aptly – but again, translating it, “being with another” or “being together in the (life-) world” are so long-winded.

I was thinking again about the concept of “hermeneutic realism” and of how this helps me to understand what “to the things themselves” means – and applying this to the mitsein I share with my patients. It came up because of this wretched head-ache I’ve had for the last week. I “know” that it is stomatognathic, and that my sphenoid is out of whack, because of where I have the pain (in my oh-so-sensitive pterions), and I can tell that my SBS is compressed and my usual easy cross-diagonal pattern of compensation has become dysfunctional. I “know” it because I have a “felt sense” of it. And this is different from migraines, tension headaches, neuralgia, sinus headaches, hang-overs and other types of headaches I’ve had in the past. Now, if “somatic dysfunction” is irrelevant and if structural “out-of-whackness” is irrelevant, what business do osteopaths have trying to ease, release, bring back into alignment, coax or fix biomechanical-structural-postural findings?

And it occurred to me – something about throwing the baby out with the bath-water! Something about osteopathy residing in the space between the intersecting comets’ tail swooshes left behind by the corporeal turn in psychology and the psychological turn in osteopathy – if we take a hermeneutic realist position on the manifold equal and co-existing truths of the ways in which patients suffer, we can help them by “being with” them in a compassionate manner that resonates with their truth – and being hermeneuts, we can help them to uncover what that truth is, for them, today. For one person, their painful sacrum

might be the result of a whiplash injury; for another it might be associated with an aching loneliness; for another it might be because of a slip on the ice; for another, it might be a pelvis that is out of alignment following child-birth; for another, it might be referred pain from the L5/S1 disc. We might use history and/or assessment to diagnose the "problem" – our working diagnosis can easily be disputed because of the deficiencies in the validity of our diagnostic techniques. We may use "exactly" the same approach (or even different approaches) to help treat/release/support/stretch the sacrum or SIJs. If they feel better, move better, exercise better, function better – that's just natural resolution, or placebo – yes, in the facile world of objectivist external reality! The problem is ontological! What we are failing to explore and account for is the fact that we have had a meaningful encounter with the patient by helping them to make sense of and resolve **their** symptoms. It takes inter-personal curiosity, open-ness, resonance and judgement (not to mention the skill to screen and account for the potential need for medical referral) to "be with" a patient in a way that empowers or enables them – and it takes skill and imagination to be able to adjust your register so that you can share your patient's perspective and treat the damn' structural dysfunction when it is crying out for it (whereas on other days, sympathy, education and a motivational chat will be more appropriate). So it does take "attunement" to understand and "be with" our patients. It takes an ability to be hermeneuts in life-worlds that are shared for a moment in time and space.

APPENDIX 5 BSO RESEARCH ETHICS COMMITTEE ANNUAL PROGRESS FORM 2017

THE BRITISH SCHOOL OF OSTEOPATHY

BSO Research Ethics Committee Annual Progress Form

This form should be completed annually by all researchers conducting primary data collection studies of greater than 12 months' duration from receipt of ethical approval. This includes studies that extend beyond 12 months due to deferral of submission.

To be completed in typescript and submitted to the Secretary of Research Ethics Committee (REC) by the researcher.

Details of principal researcher

Name	Mandy Banton
Supervisor (if applicable)	Steven Vogel
Title of project	Making Sense of Cranial Osteopathy: An Interpretive Phenomenological Analysis and Meta-Narrative Literature Review
REC approval date	20th June 2017

Progress

Has the study started? Yes ☒No ☐. If no, please go to section 4.
If yes, what was the start date? 10th February 2017 (date of the first interview)
Has the study finished? Yes ☐No ☒.
Number of participants recruited.
8
Number of participants completed the study.
6 – still awaiting confirmation that the remaining two will consent for their transcribed data to be used.
Number and reason for not completing the study.
Withdrawal of consent:
Loss to follow-up:
Other (please provide details):

Have there been any serious difficulties in recruiting participants? Yes ☐No ☒. If Yes, please give details.
Do you plan to change the recruitment process the study? Yes ☐No ☒. For governance of amendments to recruitment, please refer to your ethical approval letter.
Have any substantial amendments been made to the study during the year? Yes ☐No ☒. If yes, please provide details.
I now plan to change the literature review component of the study – not to conduct a meta-narrative literature review, but to conduct a less structured review. I have not yet completely revised my proposed methodology, and therefore have not yet sought approval of the REC.
Was formal approval sought from and given by the REC for these amendments? Yes ☐No ☒. If no, please explain why formal approval for the amendments was not sought.
As above – I am uncertain as yet whether my new literature review method will constitute a substantial amendment.

Safety of participants

Have there been any related and unexpected adverse events in this study? Yes ☐No ☒. If no, please go to section 5.
Have these events been notified to your supervisor (if applicable) and the REC? Yes ☐No ☐. If no, please complete the adverse events form that came with this form.
Have there been any minor safety concerns with this study? Yes ☐No ☐. If yes, please provide details and how they were addressed.

Studies yet to begin

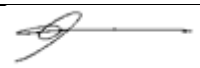
Please provide details of reasons for the study having not begun.
What is the expected start date?
What is the expected completion date? If you expect the study to overrun the planned completion date you should notify the REC secretary.
Are any amendments to the study needed, planned or under consideration? Yes ☐No ☐.

If yes, please provide details.
If you do not expect the study to be completed, please provide reason(s).

Other issues

Are there any other developments in the study that you wish to report to the Committee? Yes ☐No ☒. If yes, please provide details.
Are there any ethical issues on which further advice is required? Yes ☐No ☒. If yes, please provide details.

Confirmation of completion of the form

Principal researcher	Signature	
	Print name	Amanda Banton
Supervisor (if applicable)	Signature	
	Print name	
	Date	19th July 2017

APPENDIX 6 E-MAIL INVITATION TO FELLOWS OF THE SCCO

Dear Colleagues,

We are conducting a qualitative study investigating cranial osteopathy, from the dual perspective of experienced cranial osteopaths and patients of theirs who have benefited from treatment. The study is being conducted by Mandy Banton, FSCCO, as part of the Professional Doctorate in Osteopathy she is undertaking at The British School of Osteopathy. The study aims to explore the understanding that osteopaths and patients have of cranial osteopathy and uses a research method based on the philosophy of phenomenology, known as Interpretative Phenomenological Analysis.

We are aiming to recruit Fellows of the Sutherland Cranial College of Osteopathy and their patients to participate in the study. Participating in the study would contribute to our understanding of the value that patients place on cranial osteopathy. Participants would be asked to give up an hour of their time in a face-to-face interview with Mandy, sharing their insights about the experience of cranial osteopathy.

If you would like to find out more, please e-mail Mandy at A.Banton@bso.ac.uk. She will send you an information pack.

Thank you!

Mandy Banton
Professional Doctorate Student
British School of Osteopathy
(Principal Investigator)

Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
(Director of Studies)

Members of the Project Team
Principal Investigator's Contact Details
Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748 604
a.banton@bso.ac.uk

Director of Studies' Contact Details
Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

Second Supervisor Details
Dr Geraldine Lee-Treweek
Principal Lecturer, Applied Social Studies
Department of Interdisciplinary Studies
Manchester Metropolitan University
CW1 5DU

Advisor Details
Sibyl Grundberg, D.O., FSCCO

APPENDIX 7 OSTEOPATH INVITATION TO PARTICIPATE

THE BRITISH SCHOOL OF OSTEOPATHY

Name of recipient
Address of recipient
Address Line 2
Address Line 3
DATE

Dear Mr/Mrs X

Study Exploring the Experience and Understanding of Cranial Osteopathy

Thank you for showing interest in the above study, which aims to investigate cranial osteopathy from the dual perspective of experienced cranial osteopaths and patients of theirs who have benefited from treatment. The study is being conducted by Mandy Banton, FSCCO, as part of the Professional Doctorate in Osteopathy she is undertaking at The British School of Osteopathy. The study aims to explore the understanding and experience that osteopaths and their patients have of cranial osteopathy. It utilises a research method based on the philosophy of phenomenology, Interpretative Phenomenological Analysis.

If you are interested in participating, your involvement would be to take part in a one-to-one interview with Mandy Banton, the principal investigator. You would also identify patients who meet the study inclusion criteria and invite them to participate in the study. Having considered the information about the study, if agreeable to taking part, your patient would then participate in a one-to-one interview with Mandy.

The patient participant inclusion criteria are that they should be patients of yours who have attended for cranial osteopathy on five or more occasions, and be willing to talk in some depth about their experience of cranial osteopathy. They should naturally be willing to consent to participate in the study, but would do so only having read the information associated with their involvement. The only exclusion criteria are that they should not be known to Ms Banton personally, or ever have been a patient of hers.

The British School of Osteopathy
Teaching Centre, 275 Borough High St, London SE1 1JE. Tel: 020 7407 0222. Fax: 020 7089 5300
Clinical Centre, 98 – 118 Southwark Bridge Road, London SE1 0BQ. Tel: 020 7089 5360. Fax: 020 7928 2156
www.bso.ac.uk
Registered in England No. 146343 Exempt charity Registered Office: As above
The British School of Osteopathy is an exempt charity which educates student osteopaths, treats patients and promotes research.

Further information about the study is found in the attached "osteopath participant information sheet" and within the enclosed "patient participant information pack". Participation or not in the study is, of course, voluntary and if you agree to take part you will be free to withdraw at any time without giving any explanation and without detriment to you. If you wish to participate in the study, or to find out more about it, please reply to Mandy by (date).

Yours sincerely,

Principal Investigator's Name and Contact Details
Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748604
a.banton@bso.ac.uk

Director of Studies' Name and Contact Details
Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

Second Supervisor Details
Dr Geraldine Lee-Treweek
Principal Lecturer, Applied Social Studies
Department of Interdisciplinary Studies
Manchester Metropolitan University
Cheshire
CW1 5DU

Advisor Details
Sibyl Grundberg, D.O., FSCCO

Encs:
1. Osteopath participant information sheet
2. Two osteopath participant consent forms
3. FAQs
4. Prepaid envelope
5. Sample patient participant information pack, containing:
    - A covering letter from you to your patient, with blank spaces for your name and address and your patient's names and addresses, which can be added by hand (alternatively, we can send you an electronic copy of the letter to which you can add your own letterhead)
    - An invitation letter from us to your patient
    - A patient participant information sheet
    - Two patient participant consent forms
    - A pre-paid envelope addressed to us so that your patients can let us know of their interest in participating in the study

APPENDIX 8 OSTEOPATH PARTICIPANT INFORMATION SHEET

THE BRITISH SCHOOL OF OSTEOPATHY

Study Exploring the Experience and Understanding of Cranial Osteopathy

Osteopath Participant Information Sheet
We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you need any further information, please contact us using the details provided below.

Study Title
Making sense of cranial osteopathy: a study exploring the experience and understanding of cranial osteopathy.

What is the purpose of the study?
We know that cranial osteopathy is popular with patients in the UK, but there is little published to explain why. There is also little published qualitative research exploring the experience and understanding that osteopaths and their patients have of cranial osteopathy. This study aims to answer questions about the popularity and experience of cranial osteopathy by allowing experienced osteopaths and their patients to discuss aspects of cranial osteopathy that have not yet been explored in a published study. The study uses a qualitative methodology known as Interpretative Phenomenological Analysis, which is suitable for exploring complex and nuanced phenomena. It also uses a qualitative approach to reviewing relevant literature that seeks to interpret and explain the philosophy and concepts underpinning cranial osteopathy.

The researcher is Mandy Banton, Fellow of the Sutherland Cranial College of Osteopathy and research student taking The British School of Osteopathy's Professional Doctorate in Osteopathy, which is a programme of study of the University of Bedfordshire.

Why have I been invited?
As a Fellow of the Sutherland Cranial College of Osteopathy, currently practising in the UK, you have the relevant training and experience to contribute to the study. The aim is for a total of five osteopaths and a patient of each of theirs to participate.

Do I have to take part?
No. It is up to you to decide to join the study or not. You should read this information sheet before deciding and contact us if you have any questions or would like further information. Participation is voluntary. Whether you choose to take part or not will have no effect on your professional standing.

Even if you choose to participate, you will be able to withdraw from the study without giving a reason and this would not have a detrimental effect on you or your practice.

What does taking part involve?
Your involvement in the study would be to participate in a one-to-one interview with the principal investigator, Mandy Banton, which would be audio-recorded and transcribed by her and checked by you. The interview is anticipated to last around an hour and the transcription would be sent to you two weeks after the interview for your approval.

Additionally, your involvement would extend to identifying patients of yours who meet the study inclusion criteria and forwarding them a letter inviting them to participate in the study. If your patient decided that they wanted to be involved in the study, they would participate in a one-to-one interview with Ms Banton, recorded and transcribed by the principal investigator and checked by your patient.

The reason for inviting you and one of your patients to participate in the study is to enable the exploration of the phenomenon of cranial osteopathy from two interlinked perspectives, and not to try to identify any differences that might arise from the two interviews. You would not hear the interview or see the transcript of your patient and your patient would not hear your interview or see your transcript.

What do I have to do next?
If you have any questions about the study, please contact us.

If you decide that you would like to take part, please sign the enclosed consent form and send it to us in the pre-paid envelope. Please retain this information sheet so that you can refer to it in the future.

If you decide that you do not wish to take part, you need take no further action.

Will my taking part in the study remain confidential?
Your patient would know that you are participating in the study, but nobody other than the principal investigator, Mandy Banton, and director of studies, Steven Vogel, would know. Neither your name, nor your patient's, would be recorded, and any identifying features would be blanked out in the transcript. Data will be collected and stored strictly in accordance with the principles of confidentiality and data security. We will follow ethical and legal practice and all information provided by participants will be handled in confidence. All information will be stored securely for six years and destroyed after this time.

What happens to the recordings made and transcripts generated?
The recordings and transcripts will initially be stored in a locked filing cabinet at the office of the principal investigator. Once the study has been completed, they will be stored in a locked filing cabinet at The British School of Osteopathy. An electronic copy will only be kept for the duration of the study on a password-protected, external USB memory stick, and on secure servers at The British School of Osteopathy. It will not be held on a personal computer or on any remote server. For the duration of the study, the memory stick will be stored in a locked filing cabinet at the office of the principal investigator. Once the study has been completed, it will be stored securely at The British School of Osteopathy and destroyed after six years. Information that might identify individuals discussed in the interview will be changed to enhance the anonymity of the transcripts. Transcripts

will be coded and will not contain the name of the interviewee. The transcript will be analysed by the principal investigator. The anonymised analysis will be audited by the project advisor, Sibyl Grundberg, and the supervisory team. Quotations from the transcriptions if used in the final project report, or other publications or presentations, will be brief and anonymised.

What are the possible benefits and risks of taking part?
There are no obvious direct benefits for you personally of taking part in this study, although you might find it interesting to reflect on your experience as an osteopath who uses cranial osteopathy. The results of the study are likely to be of interest to you, other osteopaths, those who access osteopathic treatment and those providing osteopathic education. There is a small risk that reflecting on your beliefs about and experience of cranial osteopathy will provoke introspection and might feel challenging. You might find it of help to discuss your concerns with a trusted colleague or with the principal investigator, who is also a Fellow of the Sutherland Cranial College of Osteopathy.

There is a very small chance that you or your patient might disclose information suggestive of professional malpractice. Were this to happen, the principal investigator would follow the Osteopathic Practice Standards 2012: Code of Practice, section C9, and initially discuss the issue with you.

What will happen to the results from the study?
The final report of the study will be submitted as a thesis for the principal investigator's Professional Doctorate in Osteopathy. We will then work towards presenting the findings of this research to relevant professional osteopathic conferences and towards publication of the findings in academic journals. Participants will receive the results of the study, unless they do not wish to. The thesis will be available in The British School of Osteopathy library after final approval.

What if I change my mind about taking part?
You can change your mind about taking part without penalty or detriment to your professional standing. Just tell the principal investigator or director of studies that you wish to withdraw. You may also decline to answer any of the individual questions in the interview. If you have consented to participate in the study, taken part in the interview, then reviewed the transcript, you may still withdraw your consent at this time. However, if you have given your consent for the transcript to be used, it would not be possible to retrospectively extract the data from the final report. If you have any concerns about this, please let us know.

What if there is a problem?
If you have a concern about any aspect of the study, you should speak to the principal investigator or director of studies who will do their best to answer your questions. If you were still to remain unhappy and might wish to complain formally you should contact the Registrar at the British School of Osteopathy who is the complaints officer for the School, Mr Phil Heeps (p.heeps@bso.ac.uk, Tel: 020 7089 5353).

Who is organising and funding the research?
The principal investigator is Mandy Banton, Fellow of the Sutherland Cranial College of Osteopathy and research student taking The British School of Osteopathy's Professional Doctorate in Osteopathy, which is validated by the University of Bedfordshire.

The director of studies is Mr Steven Vogel, Vice-Principal (Research) at The British School of Osteopathy. The second supervisor is Dr Geraldine Lee-Treweek, Principal Lecturer, Applied Social

Sciences, at Manchester Metropolitan University. The project advisor is Ms Sibyl Grundberg, D.O., Fellow of the Sutherland Cranial College of Osteopathy.

Who has reviewed the study?
The study has been reviewed by the Research Ethics Committee of The British School of Osteopathy. The project has been approved by the University of Bedfordshire's Research Ethics Committee.

Please contact us about any aspect of the study. Thank you for your time in considering participation in this research study, which is greatly appreciated.

Principal Investigator's Name and Contact Details
Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748604
a.banton@bso.ac.uk

Director of Studies' Name and Contact Details
Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

THE BRITISH SCHOOL OF OSTEOPATHY

Study Exploring the Experience and Understanding of Cranial Osteopathy
Frequently Asked Questions – Osteopaths

How do I find out more about the study?
Please contact Mandy Banton or Steven Vogel:

Principal Investigator's Name and Contact Details	Director of Studies' Name and Contact Details
Mandy Banton	Mr Steven Vogel
Professional Doctorate Student	Vice Principal (Research)
British School of Osteopathy	British School of Osteopathy
275 Borough High Street	275 Borough High Street
City of London	City of London
SE1 1JE	SE1 1JE
07572 748604	020 7089 5331
a.banton@bso.ac.uk	s.vogel@bso.ac.uk

I would like to take part in the study, so what is the next step?
Please sign a consent form and send it in the prepaid envelope to Mandy Banton. She will then contact you to arrange a time and place for the interview, and will send you several patient participant information packs.

What type of patient would be a suitable participant for the study?
Patients invited to participate in the study must meet the following criteria:

- Be adult patients (aged 18 or over) of osteopaths who have agreed to participate in the study
- Be patients who have attended for cranial osteopathy on five or more occasions
- Be willing to talk in some depth about their experience of cranial osteopathy
- Be willing to consent to participate in the study

Excluded from the study will be:

- Patients who are known to Mandy Banton on a personal level or as a patient.

How should I approach patients who might be interested in taking part?
Please think of two or three patients who would be suitable for the study and send them the suggested letter and patient participant information packs. You might like to mention the study to them when you see them, or even telephone them to let them know that you will be sending them

the letter and information pack. Only one patient is required, and the interview will be arranged with the first person who replies to confirm that they would like to take part.

You might like to say, "I am taking part in an in-depth study about the experience and understanding that osteopaths and their patients have of cranial osteopathy, and would like to invite you to take part too. You are under no obligation whatsoever to take part, but may I send you a letter and information pack to look through?"

What if patients ask me about the study?
The patient participant information packs contain an information sheet and an invitation for patients to get in touch with the principal investigator or director of studies if they have additional questions. You may wish to say that you have reviewed the material and are happy to be involved with this interesting and in-depth study. The information sheet also states that the research has been peer reviewed and approved by The British School of Osteopathy and the University of Bedfordshire's Research Ethics Committees.

Will I be involved in arranging the patient's interview?
No. This is something that will be arranged between Mandy Banton and the patient.

Will I see my patient's interview transcript?
No, you will not have access to your patient's interview transcript. This will be kept confidential.

Will my patient see my interview transcript?
No, your patient will not have access to your interview transcript. This, too, will be kept confidential.

What if I change my mind and do not want to take part?
You can change your mind about taking part without penalty or detriment to your professional standing. Just tell the principal investigator or director of studies that you wish to withdraw. You may also decline to answer any of the individual questions in the interview. If you have consented to participate in the study, taken part in the interview, then reviewed the transcript, you may still withdraw your consent at this time. However, if you have given your consent for the transcript to be used, it would not be possible to retrospectively extract the data from the final report. If you have any concerns about this, please let us know.

What if my patient changes their mind and does not want to take part in the study?
We will inform your patient that they can change their mind about taking part without penalty or detriment to their current or future osteopathic care.

APPENDIX 10 COVERING LETTER FROM OSTEOPATH TO PATIENT

Osteopath's Address
First Line Address
Second Line Address
Town/City
Postcode

Patient's Firstname Lastname
First Line Address
Second Line Address
Town/City
Postcode

Date

Dear Title Lastname,

Study Exploring the Experience and Understanding of Cranial Osteopathy

I am taking part in a research project led by Ms Mandy Banton, a cranial osteopath who is studying for her professional doctorate. As part of this work she is wanting to interview patients about their experience of osteopathic treatment with me.

I would be grateful if you could take a few moments to read the attached letter and information sheet about the study from Ms Banton.

In summary, the study involves having an interview, which would be recorded, with Ms Banton. It would last about an hour and would be arranged at a time and location convenient to you. I would also be interviewed separately about the osteopathic treatment I give you, but only if you decide to take part in the research.

Whether you take part or not in the study will have no effect on your current or future osteopathic care, and you should feel under no obligation to participate. The study has been approved by The British School of Osteopathy and University of Bedfordshire Research Ethics Committees.

Having read the information sheet, if you would like to take part please complete the enclosed consent form and return it back to Ms Banton directly.

If you have any questions or would like further information about the study before deciding whether or not you would like to be involved, please contact Ms Banton or her director of studies, Steven Vogel, directly.

Yours sincerely,

Osteopath's Signature and Name

APPENDIX 11 PATIENT INVITATION TO PARTICIPATE

THE BRITISH SCHOOL OF OSTEOPATHY

Name of recipient
Address of recipient
Address Line 2
Address Line 3
DATE

Dear Mr/Mrs X

Study Exploring the Experience and Understanding of Cranial Osteopathy

My name is Mandy Banton and I am a Fellow of the Sutherland Cranial College of Osteopathy, with a practice in the North of England. I am currently undertaking a Professional Doctorate in Osteopathy at The British School of Osteopathy.

I would like to invite you to take part in a research study exploring the experience of cranial osteopathy, from the perspective of patients who have benefited from cranial osteopathy, as well as from their osteopaths. My supervisors are Mr Steven Vogel, Vice-Principal (Research) at The British School of Osteopathy and Dr Geraldine Lee-Treweek, Principal Lecturer, Applied Social Sciences, at Manchester Metropolitan University. My project advisor is Ms Sibyl Grundberg, D.O., FSCCO.

If you decided to take part in the study, your involvement would be to have a one-to-one interview with me (as principal investigator) which would be audio-recorded and transcribed by me and checked by you. The interview is anticipated to last around an hour and the transcription would be sent to you two weeks after the interview for your approval. Your cranial osteopath would also participate in a separate one-to-one, semi-structured interview with me.

The reason for inviting both you and your osteopath to participate in the study is to explore cranial osteopathy from both the patient's and the practitioner's perspective rather than to identify differences that might arise from the two interviews. You would not see the transcript of your osteopath and your osteopath would not see your transcript.

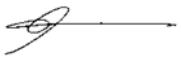
The British School of Osteopathy
Teaching Centre, 275 Borough High St, London SE1 1JE. Tel: 020 7407 0222. Fax: 020 7089 5300
Clinical Centre, 98 – 118 Southwark Bridge Road, London SE1 0BQ. Tel: 020 7089 5360. Fax: 020 7928 2156
www.bso.ac.uk
Registered in England No. 146343 Exempt charity Registered Office: As above
The British School of Osteopathy is an exempt charity which educates student osteopaths, treats patients and promotes research.

Neither your name, nor your osteopath's, would be recorded, and any identifying features would be blanked out in the transcript. Data will be collected and stored strictly in accordance with the principles of confidentiality and data security.

Further information about the study is found in the attached information sheet. Participation in the study is completely voluntary and if you choose not to participate this will have no bearing on your relationship with your osteopath, or on your current or future osteopathic care. You should feel under no obligation to participate just because your osteopath has invited you. If you agree to take part you will be free to withdraw at any time without giving any explanation and without affecting your treatment.

If you wish to participate in the study, or to find out more about it, please reply to me by (date). Two copies of a consent form are enclosed. If you wish to consent to participate, please sign both copies, keep one for your records, and return the other in the pre-paid envelope.

Yours sincerely,



Mandy Banton
BA (Hons), BSc (Hons), Registered Osteopath, FSCCO

Encs:

- Patient participant information sheet
- Two copies of patient participant consent form
- Prepaid envelope

Principal Investigator's Name and Contact Details
Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748604
a.banton@bso.ac.uk

Director of Studies' Name and Contact Details
Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

APPENDIX 12 PATIENT PARTICIPANT INFORMATION SHEET

THE BRITISH SCHOOL OF OSTEOPATHY

Study Exploring the Experience and Understanding of Cranial Osteopathy

Patient Participant Information Sheet

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you need any further information, please contact us using the details provided below.

Study Title
Making sense of cranial osteopathy: a study exploring the experience and understanding of cranial osteopathy.

What is the purpose of the study?
We know that cranial osteopathy is popular with patients in the UK, but few studies have explained why. This study aims to answer questions about the popularity and experience of cranial osteopathy by allowing experienced osteopaths and their patients to discuss aspects of cranial osteopathy that have not yet been explored in an in-depth study. The study uses a methodology known as Interpretative Phenomenological Analysis, which is suitable for exploring people's understanding of their experiences.

The researcher is Mandy Banton, Fellow of the Sutherland Cranial College of Osteopathy and research student taking The British School of Osteopathy's Professional Doctorate in Osteopathy, which is a programme of study of the University of Bedfordshire.

Why have I been invited?
You have been invited because you are a patient of an osteopath who is taking part and you have had more than five cranial osteopathy treatments. The aim is for a total of five osteopaths and a patient of each of theirs to participate.

Do I have to take part?
No. It is completely up to you to decide to join the study or not. You should read this information sheet before deciding and contact us if you have any questions. Taking part or not is up to you. Whether you choose to take part or not will have no effect on your current or future osteopathic care. You should feel under no obligation to take part just because your osteopath has invited you. Even if you choose to take part, you will be able to withdraw from the study without giving a reason and without any negative impact.

What does taking part involve?
Your involvement in the study would be to take part in a one-to-one interview with the principal investigator, Mandy Banton, which would be audio-recorded and transcribed by her and checked by you. The interview is expected to last around an hour and the transcription would be sent to you two weeks after the interview for your approval. Your cranial osteopath would also participate in a one-to-one, semi-structured interview with the principal investigator. You would not hear your osteopath's interview or see the transcript of the interview, and your osteopath would not hear your interview or read the interview transcript.

The reason for inviting both you and your osteopath to take part in the study is to explore the experience of cranial osteopathy from two interlinked perspectives, and not to try to identify any differences that might arise from the two interviews.

Neither your name, nor your osteopath's, would be recorded, and any identifying features would be blanked out in the transcript. Data will be collected and stored strictly in accordance with the principles of confidentiality and data security.

What do I have to do next?
If you have any questions about the study, please contact us.

If you decide that you would like to take part, please sign the enclosed consent form and send it to us in the pre-paid envelope. Please retain this information sheet so that you can refer to it in the future.

If you decide that you do not wish to take part, you need take no further action.

Will my taking part in the study remain confidential?
Your osteopath would know that you are participating in the study, but nobody other than the principal investigator, Mandy Banton, and director of studies, Steven Vogel, would know. Neither your name, nor your osteopath's, would be recorded, and any identifying features would be blanked out in the transcript. Data will be collected and stored strictly in accordance with the principles of confidentiality and data security. We will follow ethical and legal practice and all information provided by participants will be handled in confidence. All information will be stored securely for six years and destroyed after this time.

What happens to the recordings made and transcripts generated?
The recordings and transcripts will initially be stored in a locked filing cabinet at the office of the principal investigator. Once the study has been completed, they will be stored in a locked filing cabinet at The British School of Osteopathy. An electronic copy will only be kept for the duration of the study on a password-protected, external USB memory stick, and on secure servers at The British School of Osteopathy. It will not be held on a personal computer or on any remote server. For the duration of the study, the memory stick will be stored in a locked filing cabinet at the office of the principal investigator. Once the study has been completed, it will be stored securely at The British School of Osteopathy and destroyed after six years. Information that might identify individuals discussed in the interview will be changed to enhance the anonymity of the transcripts. Transcripts will be coded and will not contain the name of the interviewee. The transcript will be analysed by the principal investigator. The anonymised analysis will be audited by the project advisor, Sibyl Grundberg, and the supervisory team. Quotations from the transcriptions if used in the final project report, or other publications or presentations, will be brief and anonymised.

What are the possible benefits and risks of taking part?
There are no obvious direct benefits for you personally of taking part in this study, although you might find it interesting to reflect on your experience as a patient who has tried cranial osteopathy. The results of the study are likely to be of interest to patients of cranial osteopathy, osteopaths and those providing osteopathic education. There is a small risk that reflecting on your beliefs about and experience of cranial osteopathy will provoke introspection and might feel challenging. You might find it of help to discuss any concerns with your osteopath or another healthcare practitioner involved with your care. You may also discuss any concerns about the research study itself with the principal investigator, who is an osteopath practising in the North of England. Like your osteopath, she is a Fellow of the Sutherland Cranial College of Osteopathy. However, although the principal investigator is an osteopath, for the purposes of this study, she is first and foremost a researcher. This means that she is not in a position to advise you about your health or about any osteopathic treatments you have had. You may also discuss your participation in the study with the director of studies, Steven Vogel.

What will happen to the results from the study?
The final report of the study will be submitted as a thesis for the principal investigator's Professional Doctorate in Osteopathy. We will then work towards presenting the findings of this research to relevant professional osteopathic conferences and towards publication of the findings in academic journals. Participants will receive the results of the study, unless they do not wish to. The thesis will be available in The British School of Osteopathy library after final approval.

What if I change my mind about taking part?
You can change your mind about taking part without penalty or negative impact on your current or future osteopathic care. Just tell the principal investigator or director of studies that you wish to withdraw. You may also decline to answer any of the individual questions in the interview. If you have consented to participate in the study, taken part in the interview, then reviewed the transcript, you may still withdraw your consent at this time. However, if you have given your consent for the transcript to be used, it would not be possible to extract the data from the final report after it has been used. If you have any concerns about this, please let us know.

What if there is a problem?
If you have a concern about any aspect of the study, you should speak to the principal investigator or director of studies who will do their best to answer your questions. If you were still to remain unhappy and might wish to complain formally you should contact the Registrar at the British School of Osteopathy who is the complaints officer for the School, Mr Phil Heeps (p.heeps@bso.ac.uk, Tel: 020 7089 5353).

Who is organising and funding the research?
The principal investigator is Mandy Banton, Fellow of the Sutherland Cranial College of Osteopathy and research student taking The British School of Osteopathy's Professional Doctorate in Osteopathy, which is a programme of study of the University of Bedfordshire.

The director of studies is Mr Steven Vogel, Vice-Principal (Research) at The British School of Osteopathy. The second supervisor is Dr Geraldine Lee-Treweek, Principal Lecturer, Applied Social Sciences, at Manchester Metropolitan University. The project advisor is Ms Sibyl Grundberg, D.O., Fellow of the Sutherland Cranial College of Osteopathy.

Who has reviewed the study?
The study has been reviewed by the Research Ethics Committee of The British School of Osteopathy. The project has been approved by the University of Bedfordshire's Research Ethics Committee.

Please contact us about any aspect of the study. Thank you for your time in considering participation in this research study, which is greatly appreciated.

Principal Investigator's Name and Contact Details
Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748604
a.banton@bso.ac.uk

Director of Studies' Name and Contact Details
Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

APPENDIX 13 OSTEOPATH ACKNOWLEDGEMENT LETTER

THE BRITISH SCHOOL OF OSTEOPATHY

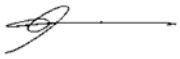
Name of recipient
Address of recipient
Address Line 2
Address Line 3
DATE

Dear Mr/Mrs X

Study Exploring the Experience and Understanding of Cranial Osteopathy

Thank you very much for agreeing to participate in the above study. Your help is greatly appreciated. I will make contact with you by telephone within the next two weeks to answer any questions you may have about inviting a patient of yours to participate in the study and to discuss the practical arrangements of coming to see you to carry out the interview.
Many thanks again for your help. Please do contact me if you have any questions.

Yours sincerely,



Mandy Banton
BA (Hons), BSc (Hons), Registered Osteopath, FSCCO

The British School of Osteopathy
Teaching Centre, 275 Borough High St, London SE1 1JE. Tel: 020 7407 0222. Fax: 020 7089 5300
Clinical Centre, 98 – 118 Southwark Bridge Road, London SE1 0BQ. Tel: 020 7089 5360. Fax: 020 7928 2156
www.bso.ac.uk
Registered in England No. 146343 Exempt charity Registered Office: As above
The British School of Osteopathy is an exempt charity which educates student osteopaths, treats patients and promotes research.

APPENDIX 14 PATIENT ACKNOWLEDGEMENT LETTER

THE BRITISH SCHOOL OF OSTEOPATHY

Name of recipient
Address of recipient
Address Line 2
Address Line 3
DATE

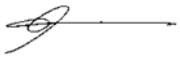
Dear Mr/Mrs X

Study Exploring the Experience and Understanding of Cranial Osteopathy

Thank you very much for agreeing to participate in the above study. Your help is greatly appreciated. I will make contact with you by telephone within the next two weeks to discuss the practical arrangements of coming to see you to carry out the interview.

Many thanks again for your help. Please do contact me if you have any questions.

Yours sincerely,



Mandy Banton
BA (Hons), BSc (Hons), Registered Osteopath, FSCCO

The British School of Osteopathy
Teaching Centre, 275 Borough High St, London SE1 1JE. Tel: 020 7407 0222. Fax: 020 7089 5300
Clinical Centre, 98 – 118 Southwark Bridge Road, London SE1 0BQ. Tel: 020 7089 5360. Fax: 020 7928 2156
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Registered in England No. 146343 Exempt charity Registered Office: As above
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APPENDIX 15 ACKNOWLEDGEMENT TO VOLUNTEERS NOT REQUIRED

THE BRITISH SCHOOL OF OSTEOPATHY

Name of recipient
Address of recipient
Address Line 2
Address Line 3
DATE

Dear Mr/Mrs X

Study Exploring the Experience and Understanding of Cranial Osteopathy

Thank you very much for considering participating in the above study. Your interest is greatly appreciated and it is very kind of you to get in touch. I regret to tell you that another person has already volunteered to participate in the study and therefore I do not require your participation at this time. I hope that this does not cause you disappointment.

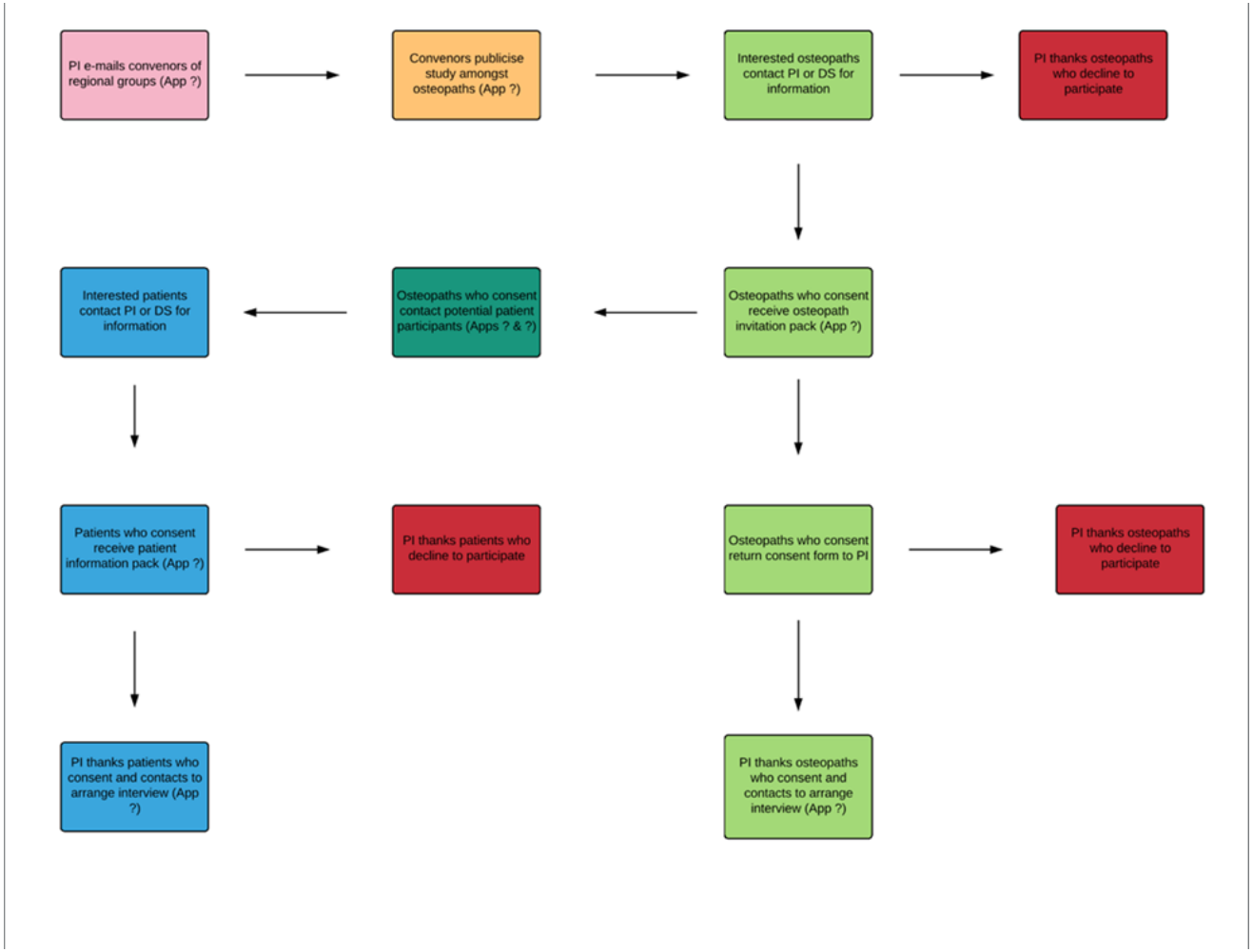
Many thanks again for your help. Please do contact me if you have any questions.

Yours sincerely,

Mandy Banton
BA (Hons), BSc (Hons), Registered Osteopath, FSCCO

The British School of Osteopathy
Teaching Centre, 275 Borough High St, London SE1 1JE. Tel: 020 7407 0222. Fax: 020 7089 5300
Clinical Centre, 98 – 118 Southwark Bridge Road, London SE1 0BQ. Tel: 020 7089 5360. Fax: 020 7928 2156
www.bso.ac.uk
Registered in England No. 146343 Exempt charity Registered Office: As above
The British School of Osteopathy is an exempt charity which educates student osteopaths, treats patients and promotes research.

APPENDIX 16 RECRUITMENT FLOW CHART



APPENDIX 17 OSTEOPATH AND PATIENT INTERVIEW SCHEDULES

Osteopath Interview Schedule

Introduction
Thank you very much for agreeing to be interviewed and for completing the consent form. I would just like to emphasise before we start that I am interested in anything you have to say about the subject and will only ask questions to prompt you. I would like to explain that I am interested in any of your thoughts, whether you have spent time reflecting on the subject or not. I am really interested in hearing you speak spontaneously about the subject – and, there are no right or wrong answers!

I will not get involved in any discussion about the subject, because I want to avoid trying to influence or lead your train of thought. In order to keep the identity of individual patients anonymous, it would be helpful if you avoided using the personal names or identifying features of any case that you might mention. However if these are mentioned I will change any such features when transcribing the interview.
We can now start the interview if that's okay with you. You can choose to pause or stop the interview at any time, for any reason, without needing to give any explanation.

Experience
Please tell me how you first came across cranial osteopathy.

And how do you tend to use cranial osteopathy in your practice, for example, as you would with Mr/s (Name of Patient Participant)?

What do you sense, perceive or feel when working cranially, for example, as you would with Mr/s (Name of Patient Participant)?

Understanding
Please tell me about your understanding of how cranial osteopathy works.

How have you developed your understanding on how cranial osteopathy works?

If your understanding of cranial osteopathy has changed over time, could you say how and why?

And if your experience of cranial osteopathy has changed over time, could you say how and why?

Communication with Patients
Please tell me what you say to your patients about how cranial osteopathy works. For example, as you would with Mr/s (Name of Patient Participant)?

Please tell me about the therapeutic relationship you have with cranial osteopathy patients, such as Mr/s (Name of Patient Participant).

Patient Interview Schedule

Introduction
Thank you very much for agreeing to be interviewed and for completing the consent form. I would just like to emphasise before we start that I am interested in anything you have to say about the subject and will only ask questions to prompt you. I would like to explain that I am interested in any of your thoughts, whether you have spent time reflecting on the subject or not. I am really interested in hearing you speak spontaneously about the subject – and, there are no right or wrong answers!

I will not get involved in any discussion about the subject, because I want to avoid trying to influence or lead your train of thought.

I should also point out that although I am an osteopath, for the purposes of this interview I am first and foremost a researcher. This means that I am not in a position to advise you about your health or about any osteopathic treatments you have had.

We can now start the interview if that's okay with you. You can choose to pause or stop the interview at any time, for any reason, without needing to give any explanation.

Experience
Please tell me how you first came across cranial osteopathy.

What sort of things does your osteopath do during your treatment?

What do you sense, perceive or feel when having cranial osteopathy?

Understanding
Please tell me about your understanding of how cranial osteopathy works, specifically from the point of view of having treatment from Mr/s Name of Osteopath Participant.

How have you developed your understanding on how cranial osteopathy works?

If your understanding of cranial osteopathy has changed over time, could you say how and why?

And if your experience of cranial osteopathy has changed over time, could you say how and why?

Communication with Osteopath
Please tell me what your osteopath has told you about how cranial osteopathy works.

Please tell me about the therapeutic relationship you have with your cranial osteopath.

APPENDIX 18 PROJECT APPROVAL BY BSO

UNIVERSITY OF BEDFORDSHIRE RS1(Review)
(This form should be typewritten)

1. Name of Student: Amanda Banton	**1a. Student Ref No:** 1228285
2. Institute: IHR	**3. Research Centre:** BSO
4. Title of report: *Making Sense of Cranial Osteopathy: an Interpretative Phenomenological Analysis and Meta-Narrative Literature Review*	**5. Programme of study:** Professional Doctorate in Osteopathy

6. Reviewer's Comments and feedback on report: *(see section 5 of the notes of guidance)*

a) Does the report set out clearly the proposed plan of work? ☒Yes ☐ No
If no please comment:

b) Is the scope of the project suitable? ☒Yes ☐ No
If no please comment:

c) Are the methodologies clearly explained and are they appropriate to the work done/to be done? ☒Yes ☐ No
If no please comment:

d) Do you believe that the student has demonstrated their capability to work at the level of approval requested? ☒Yes ☐ No
If no please comment:

Recommendations and further comments, please use the space below:

7. Recommendation of the reviewer: *(see notes of guidance)* **delete as applicable*

i) the proposal is approved for onward transmission to RDC

8. Name of Reviewer: **Stephen Tyreman**	**Signature:** 	**Date:** **14/06/2016**

To the Reviewer: please forward to the Research Administrator on completion, retaining a copy for your own records.

9. Decision of Director of Institute - *(Include instruction for Student as appropriate)*

i) the proposal is approved for onward transmission to RDC

10. Name of Director of Institute: Dr Yannis Pappas	**Signature:** 	**Date:** **17.06.2016**

To the Director of Institute: please return to the Research Administrator on completion, retaining a copy for your own records

11. Action taken by RGS:	Copy of review forms to student & Director of Studies (advising action): - i. RS1 and review forms forwarded to RDC	**Date: 17 June 2016**

April 2014 1

APPENDIX 19 PROJECT APPROVAL BY UNIVERSITY OF BEDFORDSHIRE'S IHR

UNIVERSITY OF BEDFORDSHIRE RS1(Review)
(This form should be typewritten)

1. Name of Student: Amanda Banton	**1a. Student Ref No:** 1228285
2. Institute: IHR	**3. Research Centre:** BSO
4. Title of report: *Making Sense of Cranial Osteopathy: an Interpretative Phenomenological Analysis and Meta-Narrative Literature Review*	**5. Programme of study:** Professional Doctorate in Osteopathy

6. Reviewer's Comments and feedback on report: *(see section 5 of the notes of guidance)*

a) Does the report set out clearly the proposed plan of work? xx☐Yes ☐ No
If no please comment:

b) Is the scope of the project suitable? x☐Yes ☐ No
If no please comment:

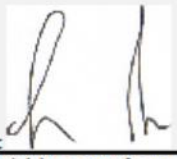
c) Are the methodologies clearly explained and are they appropriate to the work done/to be done? x☐Yes ☐ No
If no please comment:

d) Do you believe that the student has demonstrated their capability to work at the level of approval requested? x ☐Yes ☐ No
If no please comment:

Recommendations and further comments, please use the space below:
The proposal is very well thought through and well written – good luck with the study.

7. Recommendation of the reviewer: *(see notes of guidance)* **delete as applicable*

i) the proposal is approved for onward transmission to RDC

8. Name of Reviewer: PROFESSOR GURCH RANDHAWA	**Signature:** 	**Date: 16/6/16**

To the Reviewer: please forward to the Research Administrator on completion, retaining a copy for your own records.

9. Decision of Director of Institute - *(Include instruction for Student as appropriate)*

i) the proposal is approved for onward transmission to RDC

10. Name of Director of Institute: Dr Yannis Pappas	**Signature:** 	**Date: 17.06.16**

To the Director of Institute: please return to the Research Administrator on completion, retaining a copy for your own records

11. Action taken by RGS:	Copy of review forms to student & Director of Studies (advising action): - i. RS1 and review forms forwarded to RDC	**Date: 17 June 2016**

APPENDIX 20 OSTEOPATH CONSENT FORM

THE BRITISH SCHOOL OF OSTEOPATHY

Study Exploring the Experience and Understanding of Cranial Osteopathy

Study Title
Making sense of cranial osteopathy: a study exploring the experience and understanding of cranial osteopathy.

Osteopath Participant Consent Sheet
If you wish to participate in this study, please complete and sign two copies of this form. Return one to the principal investigator in the pre-paid envelope and keep the other for your records. Please remember to complete your contact details so that the principal investigator can contact you to arrange the interview. She will aim to be in touch with you within two weeks of receiving your consent form or queries.

	Please put your initials in the box to indicate your acceptance.
I understand the nature and purpose of the study	☐
I have had the opportunity to discuss the study with the principal investigator and director of studies	☐
I understand that participation will entail inviting a patient of mine to take part in the study	☐

I understand that participation will entail giving an interview which will be recorded and transcribed ☐

I understand that the content of the interview will be confidential to the principal investigator and director of studies ☐

I understand that I can withdraw at any time, even after the interview has started, without giving a reason ☐

I understand that brief, anonymous extracts from the interview may be reproduced in reports, academic publications and presentations. ☐

I understand that participants will be asked to comment on the transcript of their interview ☐

I wish to take part in this study ☐

Signed:

.....

Date:

Name: .....

Address: .....

.....

.....

Postcode: .....

E-mail address: .....

Preferred telephone number: .....

Alternative telephone number: .....

Principal Investigator's Name and Contact Details

Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748604
a.banton@bso.ac.uk

Director of Studies' Name and Contact Details

Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

APPENDIX 21 PATIENT CONSENT FORM

THE BRITISH SCHOOL OF OSTEOPATHY

Study Exploring the Experience and Understanding of Cranial Osteopathy

Study Title
Making sense of cranial osteopathy: a study exploring the experience and understanding of cranial osteopathy.

Patient Participant Consent Sheet

If you wish to participate in this study, please complete and sign two copies of this form. Return one to the principal investigator in the pre-paid envelope and keep the other for your records. Please remember to complete your contact details so that the principal investigator can contact you to arrange the interview. She will aim to be in touch with you within two weeks of receiving your consent form or queries.

	Please put your initials in the box to indicate your acceptance.
I understand the nature and purpose of the study	☐
I have had the opportunity to discuss the study with the principal investigator and director of studies	☐
I understand that participation will entail giving an interview which will be recorded and transcribed	☐

I understand that the content of the interview will be confidential to the principal investigator and director of studies ☐

I understand that I can withdraw at any time, even after the interview has started, without giving a reason ☐

I understand that brief, anonymous extracts from the interview may be reproduced in reports, academic publications and presentations. ☐

I understand that participants will be asked to comment on the transcript of their interview ☐

I wish to take part in this study ☐

Signed:

.....

Date:

.....

Name:

Address: .....

.....

.....

Postcode: .....

E-mail address: .....

Preferred telephone number: .....

Alternative telephone number: .....

Principal Investigator's Name and Contact Details

Mandy Banton
Professional Doctorate Student
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
07572 748604
a.banton@bso.ac.uk

Director of Studies' Name and Contact Details

Mr Steven Vogel
Vice Principal (Research)
British School of Osteopathy
275 Borough High Street
City of London
SE1 1JE
020 7089 5331
s.vogel@bso.ac.uk

APPENDIX 22 TRANSCRIPT CHECK LETTER

THE BRITISH SCHOOL OF OSTEOPATHY

Name of recipient
Address of recipient
Address Line 2
Address Line 3
DATE

Dear Mr/Mrs X

Study Exploring the Experience and Understanding of Cranial Osteopathy

Thank you very much for taking the time to be interviewed on (date).

We would be grateful if you would review the transcription of the interview. If you would like to make changes or clarify some of your answers please annotate the copy or provide us with your comments.

If you could return the transcript to us within two weeks we would be most grateful.

Many thanks again for your help. If you have any questions or need further information then please contact Mandy Banton (principal investigator) or Steven Vogel (director of studies) at The British School of Osteopathy, 275 Borough High Street, London, SE1 1JE. Ms Banton can be reached via e-mail at a.banton@bso.ac.uk (telephone: 07572 748604) and Mr Vogel at s.vogel@bso.ac.uk (telephone: 020 7089 5331).

Yours sincerely,

Mandy Banton
BA (Hons), BSc (Hons), Registered Osteopath, FSCCO

Encs:

- Transcript of your interview
- Pre-paid envelope

The British School of Osteopathy
Teaching Centre, 275 Borough High St, London SE1 1JE. Tel: 020 7407 0222. Fax: 020 7089 5300
Clinical Centre, 98 – 118 Southwark Bridge Road, London SE1 0BQ. Tel: 020 7089 5360. Fax: 020 7928 2156
www.bso.ac.uk
Registered in England No. 146343 Exempt charity Registered Office: As above
The British School of Osteopathy is an exempt charity which educates student osteopaths, treats patients and promotes research.

APPENDIX 23 BSO REC APPROVAL

THE BRITISH SCHOOL OF OSTEOPATHY

Name: Amanda Banton
Supervisors: Steven Vogel (Internal), Dr Geraldine Lee-Treweek (External), Sibyl Grundberg (External)
Title: Making Sense of Cranial Osteopathy: An Interpretative Phenomenological Analysis and Meta-Narrative Literature Review

Monday, 20th June 2016

Dear Amanda

Outcome: Approved

Thank you for your application to the BSO REC. Your submission has been approved without further changes. You are free to begin your dissertation.

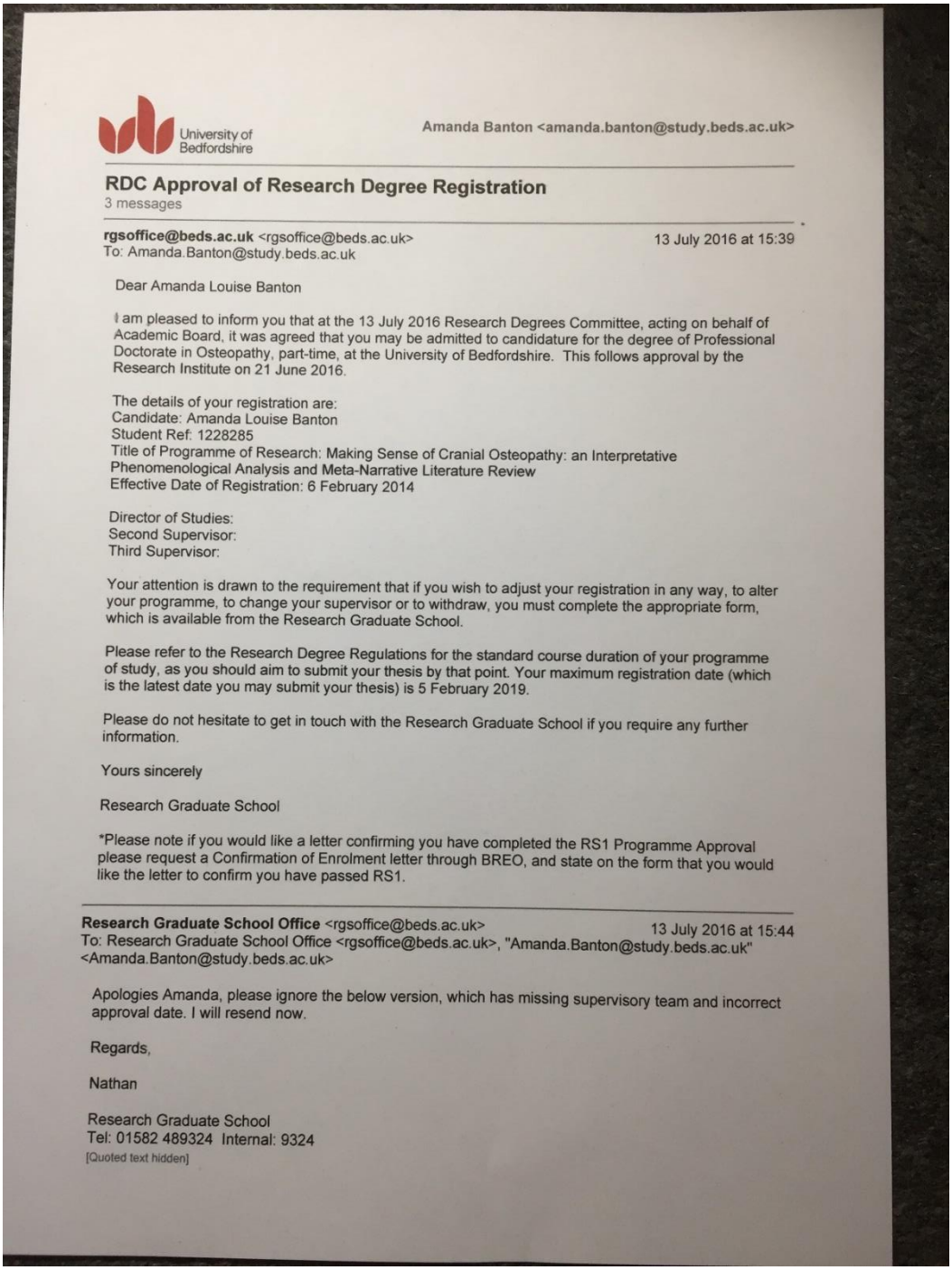
Please refer to Table 1 on Page 2 of this document for information on the governance of requests for post-approval changes to projects.

If you have any questions or queries regarding your feedback then please do not hesitate to contact REC Secretary Mike Ford on either m.ford@bso.ac.uk or 0207 089 5330.

Yours sincerely,

Mike Ford
p.p. Dr. Alan Ruben
BSO Research Ethics Committee Chair.

APPENDIX 24 UNIVERSITY OF BEDFORDSHIRE ETHICS APPROVAL



University of Bedfordshire

Amanda Banton <amanda.banton@study.beds.ac.uk>

RDC Approval of Research Degree Registration
3 messages

rgsoffice@beds.ac.uk <rgsoffice@beds.ac.uk> 13 July 2016 at 15:39
To: Amanda.Banton@study.beds.ac.uk

Dear Amanda Louise Banton

I am pleased to inform you that at the 13 July 2016 Research Degrees Committee, acting on behalf of Academic Board, it was agreed that you may be admitted to candidature for the degree of Professional Doctorate in Osteopathy, part-time, at the University of Bedfordshire. This follows approval by the Research Institute on 21 June 2016.

The details of your registration are:
Candidate: Amanda Louise Banton
Student Ref: 1228285
Title of Programme of Research: Making Sense of Cranial Osteopathy: an Interpretative Phenomenological Analysis and Meta-Narrative Literature Review
Effective Date of Registration: 6 February 2014

Director of Studies:
Second Supervisor:
Third Supervisor:

Your attention is drawn to the requirement that if you wish to adjust your registration in any way, to alter your programme, to change your supervisor or to withdraw, you must complete the appropriate form, which is available from the Research Graduate School.

Please refer to the Research Degree Regulations for the standard course duration of your programme of study, as you should aim to submit your thesis by that point. Your maximum registration date (which is the latest date you may submit your thesis) is 5 February 2019.

Please do not hesitate to get in touch with the Research Graduate School if you require any further information.

Yours sincerely

Research Graduate School

*Please note if you would like a letter confirming you have completed the RS1 Programme Approval please request a Confirmation of Enrolment letter through BREO, and state on the form that you would like the letter to confirm you have passed RS1.

Research Graduate School Office <rgsoffice@beds.ac.uk> 13 July 2016 at 15:44
To: Research Graduate School Office <rgsoffice@beds.ac.uk>, "Amanda.Banton@study.beds.ac.uk" <Amanda.Banton@study.beds.ac.uk>

Apologies Amanda, please ignore the below version, which has missing supervisory team and incorrect approval date. I will resend now.

Regards,

Nathan

Research Graduate School
Tel: 01582 489324 Internal: 9324
[Quoted text hidden]

APPENDIX 25 TRANSCRIPT OF RESEARCHER'S INTERVIEW WITH DIRECTOR OF STUDIES

Mandy: It might be like entrainment
SV: Right
Mandy: I think it might be like, if I sit next to somebody who is having a panic attack and I breathe very, very slowly, and they gradually bring their breathing down to a quieter rate and, if I'm a very still presence, that I can influence, you know, their physiological mechanism by, umm, by being sensitive and then giving a kind of physical counter-balance to how they're feeling
SV: That's really helpful and moves us onto the next bit, but just before we leave that, can I just revisit a little bit that which we've talked about a bit: how do you know what it is you're gonna do, 'cos you've actually talked a bit about that
Mandy: Mmm
SV: I just want to understand that: you've taken this really, you know, detailed . . . history, and in many ways it sounds like what, what, not your experience, it sounds like what you do is take a detailed medical history, which includes, you know, a broad biopsychosocial and indeed kind of added-value structural, ergonomic, contextual, detailed history, yeah?
Mandy: Hmm-mm
SV: And you come to some conclusions with that
Mandy: Mm
SV: And you said earlier, umm, you said earlier that you usually know where to go
Mandy: Mm
SV: In terms of palpation and stuff
Mandy: Mm
SV: Then, sorry, I'm just getting this clear in my head; is that alright?
Mandy: Hmm-mm!
SV: Yeah; so, you know you said you've got this big, this kind of detailed history, which gives you some sort of sense of stuff that's important and stuff that isn't, yeah?
Mandy: Mm
SV: And then you said earlier that I normally know where to go, and then when you talked about that you said things like, umm, you talked particularly about not wanting to upset it, or be
Mandy: Mm
SV: Or be too – risk kind of harm, really, by going to close to it
Mandy: Mm
SV
so if it's neurological, not the head; if it's kind of wound or scar, distance away.
Mandy
Mm
SV
yeah
Mandy
Mm-hm
SV
umm, but I'm also kind of interested in, in . . ., how, cos this is about how you work cranially
Mandy
Mm-hm
SV
I'm interested in how you put together your kind of medical, psychosocially, kind of evaluation, with your diagnostic experience of the kind of system of a whole, and turbulence
Mandy
Mm
SV

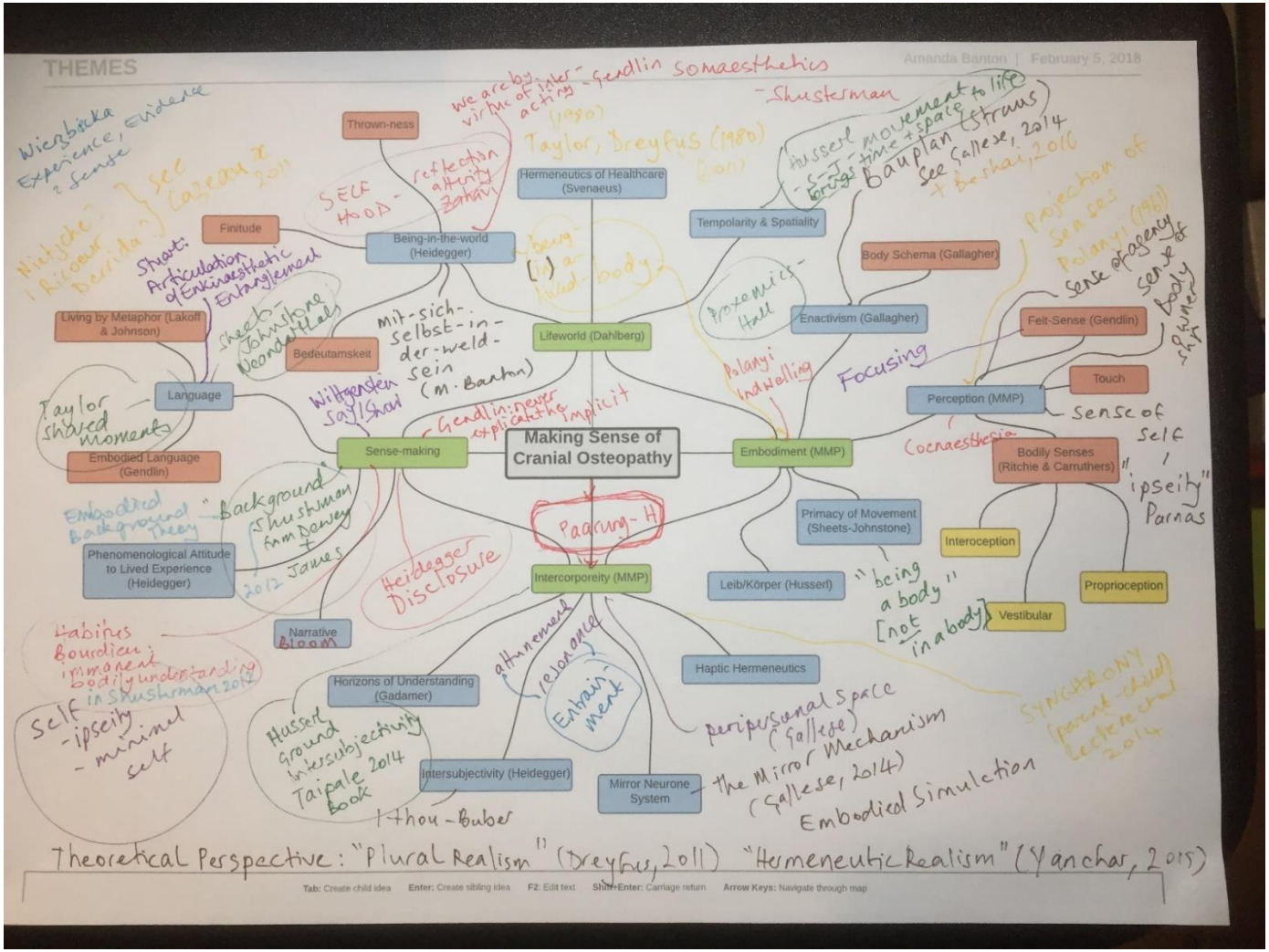
And, and, as you say, we'll go on to the mechanisms of how you kind think that might work for you [inaudible]; so I'm interested in how those things come together in your own experience; is that clear?
Mandy
Umm, maybe, let me start answering, and then you can tell me if I'm not on the right track
SV
well, you're on the right track, whatever
Mandy
(laughs) thank you (laughs). I suppose, that, err, if . . . so, just by dint of being an osteopath and not being GPs and not being psychologists, we do believe that there are some anatomical, functional, physical determinants of symptoms, so I think that my model is pretty osteopathic model, and I'm using the cranial approach specifically for carrying out and enacting the assessment and treatment plan that follows on, possibly logically from my differential diagnosis and my clinical reasoning, cos, you know, by the end of the session, err, you know, the first time or maybe the second time that I've seen somebody, I will have a working diagnosis that looks pretty much like any other osteopath's working diagnosis; maybe occasionally with a few little bits of cranial terminology in there, but, you know, I will still be thinking in terms of, umm, you know, mechanical low back pain or radiculopathy or, umm, you know, cervicogenic headache, or, err, umm, you know, sinus-related headaches or stomatognathic headaches, so, so, so I think that my assessment and treatment model is, umm, I mean, obviously I started off by talking about this broad appreciation of a person's umm quality of their mechanism, but, but, but, my thinking is still about how those symptoms are being produced, maintained or sustained by all of the other things as well; have I gone down a track that's useful?
SV
no, you know, I said it with a bit of a light tone, but it is all, it is all useful
Mandy
Mm
SV
Umm
Mandy
Mm; but did I answer the question?
SV
Well, you got close to it, so, so, I suppose where I'm at, I'm thinking about the, I'm thinking about how you know what to do, given that, you know, given that that working diagnosis, and given the intervention, so I suppose it's kind of like, you know, are there things with your cranial, with what you sense, perceive or feel when you are working , or what you are doing when you are working cranially, that are . . . germane to someone with non-specific low back pain, or are germane with someone with sinus problems, or is it a kind of a . . . . . another, is it another mechanism of system by which a kind of a global system, I suppose that this is what I'm not clear about, yeah
Mandy
Mm; so I think that what it is is a holistic system, I do think it's a holistic system, I think it's a system that believes that things that are happening in one cell would be communicated to the other cells in the body, not necessarily with the same intensity, but I think that, umm, you know, you know this idea that Walter McKone goes on about when he talks about the holographic principle, where, umm, yeah, health is expressed in, umm, in all cells equally or can be diminished in all cells equally, and you will have an imprint of a trauma, umm, that is replicated in a holo-holgraphic way in all tissues, and I think that this is something that Barrall will talk about as well, so I think that cranial osteopathy says, you know, we're not just looking at inter-linked bits of anatomy and physiology, we're looking at things that can, err-umm, that can umm, be, err, umm, can be experienced within a patient system-wide, and can be therefore assessed and umm picked up and treated system-wide, and, so, I think, I think, it is quite holistic, but, say, let's say, let's go to a person with sinus problems, because I think maybe it would help to think just think more specifically about a specific case; now, umm, this problem with sinuses problems – let's say it's something that has acutely flared up, but it's something they have had chronically, umm, I would be thinking about their history, for example, have they had a tonsillitis or gromits when they were a kid or if they had been prone to inner ear infections, umm, I would be

thinking about their, umm, whether they have asthma, whether they have, umm, you know, forward head posture, whether they are mouth-breathers, or nose-breathers, whether [phone rings at 01
26 – gap until 01
18
20}
Mandy
well as you know, I've put a lot of thought into this over time and I haven't looked to find definitive answers at this stage but/and I'm playing around with some, some ideas and I've always had a strong idea, umm, that, that the parasympathetic nervous system plays an important part within a treatment session, within an osteopathic treatment session, and probably you know obviously not exclusively osteopathy, but probably within all body work, aannd, the, err, I have a sense that, by engaging with my patient's, I'm gonna use the word mechanism; it's a proxy for I don't know what; but I'm gonna keep on using it for now; by engaging with my patient's mechanism, I am promoting a state within their autonomic nervous system that leads towards parasympathetic predominance, and, within that state of parasympathetic predominance, umm, a patient is somehow able to perhaps find a way back into their own template of their body, their own body map or their own schema of their body, which brings them into even their own interoception, using their proprioception, bringing them into a feeling of being better balanced, and, I, you know, all osteopathy says that it's about, err, you know, facilitating the healing process, err, you know, some of the original osteopathic principles are that, you know, the body's got its own medicine chest and all the rest of it, the idea is we're, we're supporting healing and I think that we're probably doing it via the parasympathetic nervous system and via some sense of umm, errr, umm, improving the patient's experience of their own embodiment, via interoceptive or proprioceptive mechanisms
SV
thank you, I'm just trying to make some notes . . . if I've understood correctly, that seems to be a kind of how it works on a . . . on a kind of meta-level, on a kind of broad-brush level
Mandy
okay
SV
if, you know, taking back you said it for example, something like, I can't remember at the beginning what I wrote down something like I truly believe things are readable and palpable, talking about an injury, or whatever it might be that's the
Mandy
yeah, acute or chronic injury
SV
yeah, the, the, kind of starring role in some respects is readable or palpable from any part of the person's body, that I can palpate, and, if you can, and you may be not be able to, can you, kind of, articulate, kind of, how that, how that works?
Mandy
Weell, I have an analogy, and I'll start off with the analogy, which is that using our, umm, umm, using our eyes and processing the things we learn to loo-, look for and see when we are assessing someone, during, for example, a standing exam, we can see how they, umm, an old ankle injury will, umm, play out and will have played out historically over time in a person's posture, we can see how that will have an impact on, umm, the levels at the pelvis, we can kind of see three-dimensional pulls within the tissue and the fascia, we can; in a sense we can, you can get a sense of, I call it the trabecular map of the individual when they are standing; and by trabecular map I mean the lines of force that will run through every tissue, essentially the grain of the tissue; you can observe that with a person standing; I think all osteopaths do that; and, and I do accept and know and believe that we need to move away from a reductive postural-structural-biomechanical models, umm, and yet I still think that we do have this remarkable, remarkable skill to be able to be able to umm, err, umm, construct sort of historical and umm err and well I suppose narratives about how a patient's injuries or err, err illnesses and circumstances in life have contributed to what they are bringing in with you on any given day; so I think so I think that we already do that; and I think that using palpation within a cranial model is a way of,

umm, doing that, using your hands, rather than using your eyes, umm, and, and maybe, you know, maybe it is something to do with whether we're more oculocentric or whether we are more, umm, whether we are more, umm, haptically driven, or attuned
SV
okay, and I might have misconstrued this, but it sounds like this is kind of like putting together lots of experience and pulling out of the top drawer a kind of umm an experience knowing tacit knowing and the schema and you know that kind of stuff from experience. I'm just interested in, you know, how that develops.
Mandy
the skill to do it?
SV
yeah, the skill to do it; I'll tell you where I'm going with that because I can see how you know whether it's true or not, whether it's testable, isn't it, whether people can spot changes and correlations in the body, and I can see how that develops, because I can see how you can look and you can get the history and you, you triangulate loads of findings, and you build up this kind of map of experience, which puts these things together, yeah?
Mandy
Mm, mm
SV
which gives you that kind of group kind of think. So I suppose I'm interested in what it is that, that, the feelings do you know where I'm going? Don't you? What are those things that make up the feeling that enables you to bring up that rich experience to put your hands on and say, okay, I can, from over here I can feel that tension or I can feel that whatever it might be – the mechanism
Mandy
Mm, mm
SV
You know, does that, might that involve, you know, those other senses, you know, might it involve putting together what you have observed, maybe, or is it, do you think it really is that, you know, in the richest sense of the word, haptic, is it a kind of haptic knowing, and again, I'm – all I'm doing with this is, is exploring your understanding of how it works, really
Mandy
Yeah, well, aaah
SV
I recognise that you might not understand
Mandy
Yeah, yeah (laughter in voice) exactly, and I suppose the thing, the other thing I haven't referred to at all, here, which is, you know, almost equally, well is probably more important, to, umm, my understanding of how it all works – the interpersonal side of things – because, you know, is it possible that, umm, that some people are more legible with eyesight and some people are more legible with palpation; or, is it that some osteopaths are better with eyesight and others are better with palpation? Or is it more to do with the way that two individuals connect? And whether the nature of that communication occurs, umm, better through certain channels than through other channels, and the reason I ask that is that we all know what it's like to, err, meet a person for the first time and pick up uncomfortable cues from their body language, okay so that's a simple, human, umm, or possibly, you know, creature-to-creature, you know, probably and encoded way of responding to each other, umm, so, I think the inter-personal or inter-creature component of it, I think, mustn't be umm you know mustn't be over-looked; and the other thing that, that I suppose I want to back-track on a little bit is this idea that what I see will be exactly the same as what you see; because, you know, would it be objectively testable that, you know, could we possibly do a good, umm, diagnostic validity study, you know, all of the evidence so far suggests that we don't have a mechanism for measuring how, umm, accurate our stories are when it comes to what we palpate and what we observe; now it might be that, that the studies are too small or the tools are too ill-equipped or we are looking for or measuring for the wrong things, but, or the other explanation might be that people communicate in different ways,

so that, you know, what you would see, if you and I were looking at the same patient with the same ankle injury, we might construct different stories that would both equally be good ways in to helping this person get better . . . . . and, and what I palpate in someone's mechanism may be different from what another person would palpate in the mechanism, and I think that this is where it comes down to – I know it sounds as though I want to have my cake and eat it, but, I just want us to be open, and I feel that I am open to the possibility that it could be, that there is this is all about the level of interpersonal communication, inter-individual communication
SV
and how, yeah, and yeah, I get that, yeah, I hear that. I guess the question arises as to this notion of commonality, you know how important is the commonality of experience, you know, how salient is it?
MB
of what experience?
SV
well, what we talked about, the interpersonal communication . . . it might be different at different levels, you know which makes you know your study so fascinating, isn't it, asking people about their experiences about how they're thinking and what they're doing, and what they, you know, what they experience, and I suppose lots of although a kind of hard, hard, kind of idealist position would be that, you know, well, you know, that's it, there is just you, your experience is a unique thing,
MB
Mm
SV
and yet, kind of much of medicine is around umm identifying common experiences and common things for taxonomies, and, you know, which goes back to kind of reliability and validity
MB
Mmm
(01
05
24 gap to 01
04
11)
SV
you know I realise that this is long and you must be getting exhausted thinking so hard

APPENDIX 26 HERMENEUTIC FORE-STRUCTURE MAP



APPENDIX 27 GLOSSARY

Term	Working Definition
Aesthetic	Pertaining to our active afferent receptivity of the phenomena of the lifeworld, using all of our senses.
Animation	The property of having life, which is synonymous with movement. The word carries the etymological sense of having breath.
Consciousness	I use this term with respect to the proposal of Sheets-Johnstone (2011) that any form possessing the feature of animation has consciousness.
Embodied Consciousness	This term is widely used in a post-Cartesian way to intend that the consciousness of beings requires the having of/being a body, and that the very substrate of consciousness is flesh-bone-neurone physicality. I use the term with the additional meaning of there being an ontological awareness of having/being a body: i.e. that our body is not silent to us as we exist in the world. I follow Sheets-Johnstone's proposition that our human bodies (and perhaps all bodies) have not only a broad capacity for physiological awareness (with which we engage homeostatically in the world), but that being/having a body entails embodied conceptual consciousness. This capacity I describe as 'the body having concepts'.
Enactive Cognition/Enactivism	I use these terms as they are elaborated by, amongst others, Gallagher (2017), to summarise the theory that cognition is a product of the interaction between living organisms and their environment. Enactive consciousness is a concept that is closely related to that of embodied consciousness.
Enactivate	I adapt this term from "Enactivism" to combine the sense of "enactment" of a law as it "comes into force" and the ritual bestowal of meaning in the act of, for example, performing a sacrament; I use it to hint at the animation of an act that has a special symbolic resonance.
Engagement	I use this term to convey the sense of an active, hermeneutic interest that additionally betokens a pledgeful contract.
Givenness	Ontologically 'immer schon' – always already there; awaiting unconcealment.
Hermeneusis	I use hermeneusis as a synonym for sense-making. In my usage, it usually carries the additional inflection of actively working to make sense of (an intentional object, or our being-in-the-world).
Holosphere	I use this term as a synonym for Lifeworld.
Illocutionary Force	I borrow this term from Tambiah (1973) who uses J.L.Austin's construction to depict the incantatory power that attends speech acts.

Lifeworld	A Husserlian term that encapsulates our experience of inhabiting a world of meaning.
Living Body	I use this term as a translation of Merleau-Ponty's Leib – the body we have/are in our lifeworld. I use it in deliberate contrast to the Anglicised versions of Körper, the body as a thing or a corpse.
Meaning	The content of our experience, or the sense that we make of phenomena. I use this term, "meaning" with reference to the Heideggerian use of "Sinn" – but not as an equivalent of it. I also use term with reference to the Heideggerian use of "Bedeutung" (Sheehan (2014).
Metaphor	I use this word with explicit reference to Lakoff and Johnson (1980a, 1980b, 2016). Our "grasp" of the world entails a linguistic evolution that originates in our being in/having an anthropoid body. All language is based on metaphor in the sense that we use words to "carry across" meaning. We do this by likening something our collocutor does not know to something s/he does know.
Multimodal	Using all of our sensory modalities.
Phenomenon	Any intentional object that reveals itself to us, or any experience that we encounter, whether we believe it to be 'real' and to have objective existence in the 'external world' or to be a feature of our imaginative or mental processes.
Plenisentient	Fully receptive, using our aesthetic attunement to the Lifeworld.
Prehension/hension	I use these terms with reference to their mooted etymological derivation: the creeping and enwrapping ivy (Hedera) that extends into its environment, clinging and grasping its way to growth. Anything that is capable of grasping is "prehensile". Our understanding of the world that is "Zuhanden", which we make sense of graspingly, is a prehensile understanding: a prehension. It is etymologically prior to "apprehension" or "comprehension". I knowingly use "seize" and "grasp" as metaphors for this mode of understanding that which is to hand.
Prenoetic	That which has meaning but at a level that has not disclosed itself to conscious recognition or reflection. It is not exactly synonymous with pre-reflective. The latter suggests that a meaning has the capacity emerge to reflective thought, whereas prenoetic suggests a meaning that can disclose itself in a way that is felt and understood in the body, without necessarily having to reveal its content to reflective thought (Gendlin, 1962).
Salience/Importance	The experience that a phenomenon has salience, prominence or importance to us: etymologically that it 'jumps out at us', and imposes itself on our awareness. I do occasionally use 'significance' as a synonym.
Senses	The afferent modalities that inform us about our world and our selves. These include sight, hearing, smell, taste, touch and the 'bodily

	senses': a vestibular sense of balance, kinaesthesia, proprioception, interoception, a sense of ipseity, a sense of embodiment.
Sense-Making	A feature of simply being in the world; we are always (to a more or less active degree) finding the meaning in all phenomena that we experience, in order that we can respond and anticipate appropriately. Sense-making has a homeostatic function, and operates in a way that is analogous to a feed-back loop. Sense-making does not always entail the conscious elaboration of explanatory theories: i.e. it is prenoetic; although it sometimes does: i.e. it is pre-reflective; sometimes it involves sensory and sub-conscious engagement with the phenomena we encounter that we barely register at a conscious or meta-conscious level.
Situated	I use this term in the manner of Larkin, Eatough, Osborn (2011) to refer to the multiple contexts of our experience of phenomena, and with a connotation of Heideggerian "Geworfenheit" or "Thrownness" or of Sartre's Facticity – i.e. the meaningful spatio-temporal context of our being-in-the-world.
Symbol/ic	I use these terms to capture a sense of significance that has an element of the ritual potency of a sacrament. That which is symbolic emanates an aura of significance, on account of its meaning to us.
Unconcealment	I use this word, along with "disclosure", "emergence" and "appearance" in the phenomenological sense of the action of the intentional object (or phenomenon) as it comes to our attention, often in response to a "peripheral glance".
Understanding	I use this word with explicit appreciation of its etymological roots – we stand beneath a conceptual horizon into which we peer in order to seek meaning.